NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

MAY 5, 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	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:
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_v290CpsiRDK_AlrnAFq-Ng and Join the Meeting.
Webinar ID: 829 0057 3731
Passcode: 288808-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

2. FY 2022-23 CalOptima Budget Planning: Part 2

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 April 7, 2022 Regular Meeting of the CalOptima Board of Directors

4. Adopt Board Resolution No. 22-0505-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

5. Authorize and Direct Execution of Amendments to CalOptima's Primary and Secondary Agreements with California Department of Health Care Services

6. Authorize and Direct Execution of an Amendment to Agreement 16-93274 ("Care Coordination Agreement") with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

7. Authorize and Direct Execution of the Cal MediConnect Three-Way Agreement Between CalOptima, the California Department of Health Services and the Centers for Medicare & Medicaid Services

8. Approve Amendment 3 to the Memorandum of Understanding for the Coordination of Behavioral Health Services with the County of Orange

9. Authorize Extension and Amendment of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith LLC

10. Authorize the Chief Executive Officer to Amend the Contract with Kennaday Leavitt PC

11. Ratification of Expenditures Related to Health Insurance Portability and Accountability Act (HIPAA) Security; Authorize Contract with Vendors Providing Security Software Services

12. Authorize Extension of Terms for Members of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

13. Receive and File the Annual 2021 Utilization Management Program Evaluation and Approve 2022 Utilization Management Program Description

14. Approve Modifications to Policy GG.1101: California Children's Services (CCS)/Whole-Child Model (WCM) – Coordination with County CCS Program

15. Approve Modifications to CalOptima Grievance and Appeals Resolution Services Policies: GG.1510, HH.1102, HH.1103, HH.1109, HH.1104, MA.9001, MA.9002, MA.9003, MA.9004, MA.9005 and MA.9009

16. Approve Modifications to CalOptima Policy HH.2005: Corrective Action Plan and Addition of CalOptima Policy AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process

17. Approval of Modifications for CalOptima Claims Administration Policies FF.1003, FF.2004, FF.2011, FF.2012 and MA.3101

18. Approve Modifications to CalOptima Policy MA.7007: Access and Availability

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

REPORTS/DISCUSSION ITEMS

20. Direct the Chief Executive Officer to Take Actions to Amend CalOptima's Ordinance to Allow for the Participation in the California Health Benefit Exchange

21. Approval of Actions Related to Homeless Health Care Initiatives

22. Approve the Criteria and Process for CalOptima to Contract with a Provider Organization under a Global Risk Health Maintenance Organization (HMO) Health Network Model

23. Authorize Extension and Amendments of CalOptima Health Network and Fee-for-Service Provider Contracts except Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., Talbert Medical Group P.C., and UC Irvine Health

24. Authorize Extension and Amendments of CalOptima Health Network Contracts for ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., Talbert Medical Group P.C., and Fee-for-Service Medi-Cal, OneCare, and OneCare Connect Provider Contracts Except UC Irvine Health

25. Authorize Extension and Amendments of CalOptima Health Network Contracts Except Kaiser Foundation Health Plan Inc. and Provider Contract for UC Irvine Health

26. Authorize the Chief Executive Officer to Negotiate, Execute and Implement ZeOmega, Inc. Contract for a Care Management System in Support of CalOptima's Digital Transformation Strategy

27. Authorize the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2023 and Execute Contract with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement (***to follow Closed Session***)

CLOSED SESSION

CS-1 Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: OneCare

CS-2 Pursuant to Government Code section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION, Orange County Digestive Center vs. CALOPTIMA, Superior Court of the State of California, County of Orange, Case No. 30-2022-01245381

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Board of Directors on May 5, 2022 at 2:00 p.m. (PST)

https://us06web.zoom.us/webinar/register/WN_v290CpsiRDK_AlrnAFq-Ng

Or One tap mobile:
+12532158782,,82900573731#,,,,*288808# US (Tacoma)
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Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 253 215 8782 or +1 346 248 7799 or +1 720 707 2699 or +1 301 715 8592 or +1 312 626 6799 or +1 646 558 8656

Webinar ID: 829 0057 3731
Passcode: 288808

International numbers available: https://us06web.zoom.us/u/kbzC9Z8btY

MEMORANDUM

DATE:	April 28, 2022
TO:	CalOptima Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — May 5, 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. Assembly Health Committee Passes AB 2724 on Kaiser's Direct Medi-Cal Contract

The Assembly Health Committee held the first public hearing on Assembly Bill (AB) 2724, which would implement Gov. Gavin Newsom's proposed no-bid, statewide Medi-Cal contract with Kaiser Permanente. The committee passed the bill without accepting any amendments requested by state trade association Local Health Plans of California or CalOptima. However, in support of your Board's action on April 7 to adopt an Oppose Unless Amended position, the Orange County Board of Supervisors approved the same position at its April 26 meeting. Next, AB 2724 will be considered by the Assembly Appropriations Committee before May 20 and then the full Assembly by May 27. In coordination with the County, CalOptima's staff and contracted lobbyists will continue to work with Orange County's state delegation to pursue an amendment preventing a direct Kaiser contract in counties with a County Organized Health System.

b. Community-Based Adult Services (CBAS) Centers Request More State Funding

As the public health emergency draws to a close mid-July, continued efforts are needed to ensure ongoing member health and safety in congregate settings, including CBAS centers that provide care for vulnerable members. CalOptima has signed a letter of support from the California Association for Adult Day Services requesting $61.4 million in additional state funding for CBAS centers to improve COVID-19 prevention and mitigation measures. As CBAS centers return to full-capacity operations in the coming months, it is critical that they have financial resources to make necessary workforce investments and facility modifications, including improved ventilation systems and physical spacing.

c. CalFresh Outreach Campaign Launched April 2022

CalOptima's CalFresh outreach campaign kicked off in April with the launch of a warm line transfer to the County of Orange Social Services Agency, a direct mailer to members who are potentially eligible to enroll in CalFresh and billboard advertising. CalOptima will host CalFresh Enrollment Events and Resource Fairs on May 6, June 11 and June 18. The events will also offer food and diaper distribution (while supplies last), community resources and fun activities for families. The full campaign will run through the fall and includes a toolkit for providers and community-based organizations, additional community events, media outreach and advertising, and other tactics to encourage enrollment in CalFresh to combat food insecurity among members. Additionally, there will be a focus on Title 1 schools to distribute awareness materials.

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d. Expansion of Medi-Cal to Undocumented Age 50+ Starts May 1

Effective May 1, CalOptima will begin to serve undocumented people age 50 and older as Medi-Cal members, under new access via AB 133 signed into law last summer. Staff estimates that approximately 17,000 may join. Undocumented children and young adults under age 26 are already eligible. A new proposal, unveiled in Gov. Newsom's proposed January budget, would expand eligibility to include remaining undocumented adults in the 26 to 49 age group. If approved in this year's final budget, the expanded coverage could start as early as 2024.

e. Be Well OC Increases Staffing With CalOptima Funding

As a result of CalOptima's recent $1 million grant, Be Well OC's Orange Campus added three new positions. The team will assist with admissions and discharge coordination to ensure timely access to services, assessment and care for CalOptima members. In reviewing campus call data from the first six months following Be Well OC's opening in 2021, 67% of the nearly 800 calls reviewed were from CalOptima members. The team will coordinate with partners co-located at the campus to ensure quick linkage to care and access to resources, including CalOptima's Mental Health Line.

f. FY 2023 Federal Earmark Requests Seek $10 Million

Staff have been working with CalOptima's contracted federal lobbyists to submit FY 2023 earmark requests seeking $10 million in federal funding for CalOptima's proposed Street Medicine Program and "Care Traffic Control" system. Specifically, the latter earmark would go toward development of a data system to digitally manage member health information.

g. Governor's CARE Court Proposal Gains Traction

Identical bills were introduced in April — Senate Bill 1338 and Assembly Bill 2830 — that would implement Gov. Newsom's proposed Community Assistance, Recovery and Empowerment (CARE) Court Program. If enacted by the Legislature, CARE Court would facilitate delivery of mental health and substance use disorder services to the most severely impaired Californians, such as those with schizophrenia spectrum or other psychotic disorders, who often experience homelessness and/or incarceration without treatment. CARE Court would connect a person in crisis with a court-ordered care plan for up to 12 months, with the option to extend an additional 12 months, to prevent conservatorships by intervening prior to the need for such restrictive services. The care plan could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan.

h. CalOptima Gains Media Coverage

- On April 7, Chief Medical Officer Richard Pitts, D.O., Ph.D., was featured in an LA Times – Daily Pilot article on CalOptima's efforts to promote CalFresh.
- Since the April 13 distribution of a press release about CalOptima's record $50 million investment in Orange County's community health centers, a number of outlets have carried the news, including OC Breeze, Becker's Payer Issues, Becker's Hospital Review, Noticias Por El Mundo and The Epoch Times.
- On April 13, California Healthline ran a profile on CEO Michael Hunn's journey from the priesthood to health care executive and his perspective on a number of timely health care topics.
- On April 18, the Orange County Business Journal published a special Healthcare Roundtable supplement featuring interviews with Orange County health care leaders, including Michael Hunn.

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FY 2022-23 Budget Planning: Part 2

Board of Directors Meeting
May 5, 2022

Nancy Huang, Chief Financial Officer

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State Budget Update

- COVID-19 Public Health Emergency (PHE) Status
  - Extended to 7/15/22
  - HHS will give states 60 days notice prior to the end of the PHE
- Medi-Cal Eligibility Redetermination
  - 14.5 million Medi-Cal beneficiaries will need to be redetermined
    - DHCS working to update contact information
    - Finding ~12% return mail rate
    - DHCS anticipates completion of redetermination process over a 12 to 14-month period
- Governor will release May Revise by 5/14/22
  - Will include updated revenue estimates and proposals to adjust expenditures

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Enrollment

- Total average members forecasted at nearly 910,000
  - Forecasting that the effects of Medi-Cal eligibility redetermination will result in a slow decline beginning September 2022
  - Effective 5/1/22, additional 15,000+ from Older Adult Expansion (i.e., undocumented and 50 or older)
  - Effective 1/1/23, transition of OneCare Connect (OCC) members will be reflected in OneCare and Medi-Cal enrollment

- By 6/30/23, staff anticipates total enrollment at 895,000 with the following distribution:
  - 98%: Medi-Cal
  - 1.9%: OneCare
  - 0.1%: PACE

Revenue

- Membership is the primary driver of revenue changes
- Medi-Cal budget will assume the following:
  - CY 2022 final rates were higher than anticipated in the approved CalOptima FY 2021-22 Operating Budget
  - CY 2023 rates are expected to remain relatively stable
- OneCare/OCC budget
  - Medicare revenue will be calculated by multiplying forecasted base rates by their corresponding risk adjustment factors

Medical Costs

- Membership is the primary driver of medical cost forecasts

- Other elements that impact medical cost projection:
  - Utilization trends
  - Unit cost adjustments
  - Service category mix
  - Existing program changes
  - New initiatives

Administrative Expenses: Personnel Cost

- Staffing levels correlate to:
  - Membership
  - Business needs
  - Regulatory requirements

- Current year budget changes that will impact the FY 2022-23 budget:
  - Updated salary schedule
  - Cost of Living Adjustment (COLA)
  - Market adjustments
  - Job re-evaluation for FY 2022-23
  - Positions added in current fiscal year
  - Supplemental pay and holiday premium

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Administrative Expenses: Non-salary Expenses

- Major drivers:
  - Expenses to support program changes
    - Professional fees (e.g., legal fees, internal and regulatory audits, consulting, strategic planning)
    - New member communication initiatives
  - Costs to support Information Technology Services (ITS)
    - Software licenses and maintenance fees
    - Contract updates/changes
    - Additional equipment needs
    - Expenses to support “Return to Office” activities

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

April 7, 2022

A Regular Meeting of the CalOptima Board of Directors was held on April 7, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom) in light of the COVID-19 public health emergency and Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirement related to teleconferenced meetings.

Chairman Andrew Do called the meeting to order at 2:07 p.m. and announced that due to audio visual technical difficulties in the first floor Board Room, the Board meeting would move from the first floor Board Room to Conference Room 915-N on the ninth floor. Chairman Do noted that members of the public would still be able to participate in the meeting in person and remotely and adjourned the meeting at 2:08 p.m. to move the meeting to the new location.

Chairman Do called the meeting to order in Conference Room 915-N at 2:21 p.m. and led the Pledge of Allegiance.

The Clerk of the Board announced that Report Item 19 will be continued due to a lack of a quorum. Chairman Do also announced that he will not be participating in Report Item 18 due to a potential conflict of interest due to campaign contributions under the Levine Act and will pass the gavel to Vice Chair Corwin.

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; Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D. (All Board Member attendees participated remotely except Chairman Do, Vice Chair Corwin, Director Schoeffel who participated in person)
Members Absent:	José Mayorga M.D.
Others Present:	Michael Hunn, Chief Executive Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Yunkyung Kim, Chief Operating Officer; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

None

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer, highlighted several items from his report, including CalOptima's new Mission and Vision approved by the CalOptima Board of Directors and the positive

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media coverage received. Mr. Hunn thanked the Board, and CalOptima's health networks, hospitals, providers, and community partners, noting that without their support, we would not be able to care for our members. Mr. Hunn also noted that the CalFresh outreach campaign kicks-off in mid-April with billboard ads and a direct mailer to members promoting that an eligible individual can received up to $250 monthly and an eligible family of four can receive up to $835 monthly in CalFresh food benefits. Mr. Hunn also provided an update on the public health emergency (PHE), which is estimated to end sometime in July of this year. He reported that eligibility redeterminations will resume and will take up to 14 months to complete. What this means is some of CalOptima members could be adversely affected and may lose Medi-Cal benefits. Mr. Hunn said staff are looking ahead to be ready to mitigate issues as they arise so members experience little to no disruption in accessing their health care services.

Chairman Do mentioned Senate Bill 1342 (SB 1342) and asked how CalOptima intended to address. SB 1342 would authorize counties to create multidisciplinary teams (MDTs) to support older adults. This bill is predicated on the ability to share information; however, that information involves protected health information (PHI) and is subject to HIPAA. Mr. Hunn responded that it will require a data sharing system and CalOptima would need to get consent from members in order to share an individual's information. CalOptima would work in collaboration with the Orange County Health Care Agency (OCHCA) and other organizations within the County to create MDTs, which would improve interagency care coordination, reduce duplication, and result in better care for these members.

2. Annual Legislative Update

Representatives from Edelstein Gilbert Robson & Smith LLC, Trent Smith and Bridget McGowan provided an overview of the current legislative environment and highlighted a few areas of focus. Topics covered included Single Payor or Universal Health Care, the homeless population, and introductory meetings with CalOptima's new leadership with the Orange County delegation.

Mr. Smith also mentioned another area of focus that will affect CalOptima and several other county organized health plans (COHS), which is the Kaiser Permanente Contract deal with the State. This would allow Kaiser to contract directly with the State and circumvent the need to go through CalOptima as the COHS in Orange County. Mr. Smith noted that this action would undermine the COHS model of care. If this direct contract is approved between the State and Kaiser, that would mean that Kaiser could take up to 25% of Medi-Cal eligible members.

Mr. Hunn added that his concern is that instead of members having access to one door for insurance in Orange County, they would have two doors. And Medi-Cal members selecting one of those doors, may not be accepted. Mr. Hunn also added that he has the utmost respect for the Kaiser doctors, nurses, leadership, and institution; however, what is important is allowing members to receive health care services in the easiest and most accessible manner possible. Because Kaiser only accepts individuals with a previous relationship with Kaiser or family member of a Kaiser member, the individuals could be turned away. Whereas, with CalOptima, who contracts with Kaiser, the door for insurance is always open, and no one is turned away.

3. Introduction to the FY 2022-23 CalOptima Budget: Part 1

Nancy Huang, Chief Financial Officer, provided an overview of the CalOptima Budget for FY 2022-23. Ms. Huang reviewed the budget objectives, which are: a balanced operating budget; building infrastructure and capacity; and improving quality and efficiency. She also reviewed the budget

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timeline, noting that the final FY 2022-23 budget will be presented to the Board for consideration at its June 2, 2022 meeting.

PUBLIC COMMENTS

- Christy Ward, CEO, Share Our Selves – Oral re: CalOptima working with California Primary Care Association (CPCA) re the Kaiser Permanente Contract deal

CONSENT CALENDAR

4. Minutes

a. Approve Minutes of the March 3, 2022 Regular Meeting of the CalOptima Board of Directors and Minutes of the March 17, 2022 Regular Meeting of the CalOptima Board of Directors
b. Receive and File Minutes of the December 8, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

5. Approve Modifications to CalOptima Quality Improvement Policies: GG.1603, GG.1607, GG.1650, GG.1651, and GG.1655

6. Receive and File 2021 CalOptima Quality Improvement Evaluation, and Recommend Board of Directors Approval of the 2022 CalOptima Quality Improvement Program

7. Receive and File 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2022 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

8. Ratify Amendments to Contract with Newmark Knight Frank

9. Retire Policies GG.1331 and GG.1350 for the Health Homes Program

10. Approve Modifications to CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements

11. Adopt Resolution No. 22-0407-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

12. Authorize Extension of Contract to Secure Transportation for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

13. Receive and File:

a. February 2022 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors approved the Consent Calendar as presented.***

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(Motion carried 8-0-0; Director Mayorga absent)

REPORTS/DISCUSSION ITEMS

14. Approve CalOptima Position on Proposed Legislation

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors: 1). Approved CalOptima's formal position on proposed Fiscal Year (FY) 2022–23 California state budget trailer bill language as follows: a.) Alternative Health Care Services Plan (RN 22 08897): OPPOSE UNLESS AMENDED; 2.) Authorized the Chief Executive Officer (CEO), or designee, to implement legislative advocacy efforts in alignment with the approved CalOptima position; and 3.) Directed the CEO to collaborate with the County Executive Office of the County of Orange to request and secure an aligned position from the Orange County Board of Supervisors. (Motion carried 8-0-0; Director Mayorga absent)***

15. Authorize Appropriation of Funds, Unbudgeted Expenditures and a Grant Agreement with the Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Orange County Coalition of Community Health Centers. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to develop and execute a five (5) year Grant Agreement with the Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation for Medi-Cal members and Medi-Cal eligible individuals; 2.) Appropriated funds and authorize unbudgeted expenditures in the amount of up to $50 million from existing reserves to fund the Grant Agreement with the Coalition of Orange County Community Health Centers; and 3.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and purpose. (Motion carried 6-0-0; Director Becerra, Director Schoeffel, and Director Mayorga absent)***

16. Authorize Appropriation of Funds from the Homeless Health Initiatives, and a Grant Agreement with the County of Orange to fund the Expansion of the Outreach and Engagement Team to Enhance to Facilitate Identification and Enrollment of Potential Medi-Cal Eligible Members

Chairman Do announced that although Director Chau is a non-voting member, he will not participate in the discussion due to his role as the Director of the Orange County Health Care Agency. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

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Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized expansion of the Board-approved homeless health initiative category "Residential support services and housing navigation" to "Residential support services, housing navigation, and outreach and engagement; 2.) Authorized the Chief Executive Officer to develop and execute a Grant Agreement with the Orange County Health Care Agency (HCA) to commit up to $7 million from the restricted Homeless Health Initiatives Reserve to fund the expansion of the Outreach and Engagement Team to facilitate identification and enrollment of potential Medi-Cal eligible members; and 3.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and purpose. (Motion carried 7-0-0; Directors Schoeffel and Mayorga absent)***

17. Authorize Actions Related to CalAIM for Community Support Services

Director Chau did not participate in this item due to his role as the Director of the Orange County Health Care Agency. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to execute contracts with any willing, qualified, and credentialed provider to provide Community Support Services pursuant to the effective dates approved by Department of Health Care Services (DHCS); and 2.) Authorized the Chief Executive Officer to execute an amendment to the contract with the County of Orange Health Care Agency to provide Community Supports Services. (Motion carried 7-0-0; Directors Schoeffel and Mayorga absent)***

18. Ratify Amendments to the Medi-Cal Health Network Contract for Health Care Services and Approve the CalAIM Community Supports Provider Incentive Payment Program Agreement

As noted at the top of the meeting, Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act and passed the gavel to Vice Chair Corwin. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors ratified: 1.) An amendment to the Medi-Cal Health Network Contract for Health Care Services, except Heritage Provider Network Inc., reflecting requirements for the California Advancing and Innovating Medi-Cal (CalAIM) Provider Incentive Payment Program, effective March 1, 2022; 2.) An Amendment to the Medi-Cal Health Network Contract for Health Care Services for Heritage Provider Network Inc. (Heritage), reflecting notice of action requirements for discontinuation of ECM services, effective March 1, 2022; and 3.) The Community Supports Provider Incentive Payment Program agreement***

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for Community Supports providers, reflecting requirements for the CalAIM Provider Incentive Payment Program, effective March 1, 2022. (Motion carried 5-0-1; Chairman Do abstained; Director Shivers recused; Directors Schoeffel and Mayorga absent)

19. Authorize Extension and Amendments of CalOptima Provider Contracts
This item was continued due to a lack of a quorum.

20. Authorize the Extension of the Quality Initiative Related to Post-Acute Infection Prevention and Authorize Related Funding for Quality Initiative Payments
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized the 3-month extension of the Post-Acute Infection Prevention Quality Initiative (PIPQI) in an amount up to $275,000 for the period of April 1, 2022, through June 30, 2022; and 2.) Authorized unbudgeted expenditures in an amount up to $275,000 from existing reserves for the PIPQI program in Fiscal Year 2021-22. (Motion carried 7-0-0; Directors Schoeffel and Mayorga absent)***

21. Adopt Resolution Approving and Adopting Updated CalOptima Policy GA.8042: Supplemental Compensation and Appropriation of Funds and Authorization of Unbudgeted Expenditures
The Clerk noted for the record, corrections to the second and third recommended actions. The April 10, 2022, date should be April 24, 2022. In addition, the last sentence on the first page starting with: "The Commuter Allowance will be in effect April 24, 2022 through July 1, 2023," the date should be through June 30, 2023. These corrections will be reflected in the archived meeting materials on CalOptima's website.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors: 1.) Adopted Resolution Approving Updated CalOptima Policy GA.8042: Supplemental Compensation; 2.) Appropriated funds and authorized unbudgeted expenditures in an amount up to $350,000 from existing reserves to fund commuter allowance for the period of ~~April 10, 2022~~, April 24, 2022 through June 30, 2022; and 3.) Appropriated funds and authorized unbudgeted expenditures in an amount up to $16,000 from existing reserves to fund holiday premium pay for the period of ~~April 10, 2022~~ April 24, 2022, through June 30, 2022. (Motion carried 8-0-0; Director Mayorga absent)*** *Rev. 4/7/2022*

ADVISORY COMMITTEE UPDATES

22. OneCare Connect Member Advisory Committee Update
Patty Mouton, Chair, OneCare Connect Member Advisory Committee (OCC MAC) provided an update on the OCC MAC activities.

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

Christine Tolbert, Chair, Member Advisory Committee (MAC) provided updates on recent MAC activities and Dr. Junie Lazo-Pearson, Chair, Provider Advisory Committee (PAC) provided updates on recent PAC activities.

Mr. Hunn thanked Ms. Tolbert and Dr. Lazo-Pearson for all of their support, feedback, and time volunteering. Mr. Hunn added that their help has been invaluable as CalOptima roll's out the new Mission and Vision and strategic priorities laid out by the Board and thanked the Chairs of the MAC and PAC and their Committee members for all of the great work they do for CalOptima.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Becerra expressed her thanks to the leadership team and the great work we have seen today and with the new leadership team in support of the new Mission and Vision to enhance health care for all beneficiaries.

ADJOURNMENT

Hearing no further business, Chairman Do adjourned the meeting at 3:54 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 5, 2022

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Adopt Board Resolution No. 22-0505-01, 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, Chief Executive Officer (657) 900-1481

Recommended Action

Adopt Board Resolution No. 22-0505-01, 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, 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, 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 March 24, 2022, to strongly recommend preventative measures such as avoiding gathering and practicing social distancing. For CalOptima to continue the teleconference meetings, the required findings are set forth in the attached Resolution No. 22-0505-01.

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 prevents 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. 22-0505-01, 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. March 24, 2022, Orange County Health Officer's Orders and Strong Recommendations
4. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn — *04/28/2022*
Authorized Signature — **Date**

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RESOLUTION NO. 22-0505-01

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;

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;

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;

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;

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;

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;

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;

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;

WHEREAS, on March 24, 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;

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;

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, 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 5th day of May, 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

REGINA CHINSIO-KWONG, DO
COUNTY HEALTH OFFICER

MATTHEW ZAHN, MD
DEPUTY COUNTY HEALTH OFFICER/MEDICAL DIRECTOR CDCD

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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS (Revised March 24, 2022)

In light of recent Face Mask Guidance issued by the California Department of Public Health (CDPH) and certain recent orders issued by the State Public Health Officer regarding COVID-19 vaccine requirements, 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 March 11, 2022. The Orders and Strong Recommendations issued on March 11, 2022, are no longer in effect as of March 24, 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 of Persons with COVID-19 Order

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 are symptom-free but test positive for COVID-19.
   If you do not have any COVID-19 symptoms (as defined below in this Order) but test

positive for COVID-19, you shall immediately isolate yourself in your home or another suitable place for at least 5 days from the date you test positive and may end your self-isolation after day 5:

- If you continue not having any COVID-19 symptoms and a diagnostic specimen collected on day 5 or later tests negative.
    - While an antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, use of an antigen test is recommended. Use of Over-the-Counter tests are also acceptable to end isolation.

Exceptions.

1) If you are unable or choose not to test on day 5 or after, or if you test positive after day 5, you shall continue your self-isolation through day 10 from the date of your initial positive test and may end your self-isolation after 10 days from the date of your initial positive test.

2) If you develop COVID-19 symptoms during the time of your self-isolation, you shall isolate yourself for at least 10 days from the date of symptom(s) onset. You may end your self-isolation sooner if a diagnostic specimen collected on day 5 (or later) from the date of symptom(s) onset tests negative.

All persons who test positive for COVID-19 should continue to wear a well-fitting mask at all times around other people through day 10.

2. Persons who have COVID-19 symptoms.

If you have COVID-19 symptoms, you shall immediately isolate yourself in your home or another suitable place for 10 days from the date of your symptom(s) onset and may end your self-isolation sooner under any of the following conditions:

- If your symptoms resolve within the first 24 hours of onset without any fever reducing agents.

- If a diagnostic specimen collected as early as the date of your symptom(s) onset tests negative.
    - While an antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, use of an antigen test is recommended. Use of Over-the-Counter tests are also acceptable to end isolation.
- If you obtain an alternative diagnosis from a healthcare provider.

Exception:

If you have COVID-19 symptoms and test positive for COVID-19, you shall isolate yourself for at least 10 days from the date of symptom(s) onset. You may end your self-isolation sooner if a diagnostic specimen collected on day 5 (or later) from the date of symptom(s) onset tests negative.

You are not required to self-isolate for more than 10 days from the date of your COVID-19 symptom(s) onset regardless of whether your symptoms are present on Day 11.

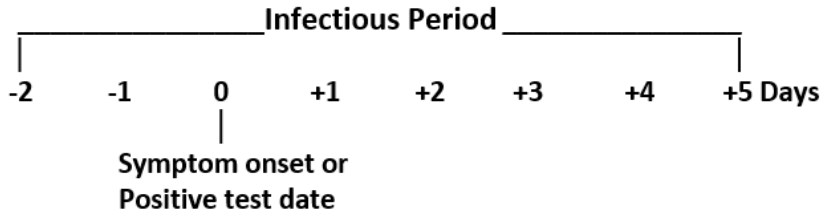
All persons who have COVID-19 symptoms should continue to wear a well-fitting mask at all times around other people through at least Day 10.

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.

Timing for "Day 0"- As noted in CDPH Isolation and Quarantine Q&A, the 5-day clock for isolation period starts on the date of symptom onset or (day 0) for people who test

positive after symptoms develop, or initial test positive date (day 0) for those who remain asymptomatic. If an asymptomatic person develops symptoms, and test positive, date of symptom onset is day 0.



Note: In workplaces, employers and employees are subject to the Isolation and quarantine requirements as stated in the CalOSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in some workplaces the Cal/OSHA Aerosol transmissible Diseases (ATD) Standard. Information about CalOSHA COVID-19 Emergency Temporary Standards (ETS) can be found at https://www.dir.ca.gov/dosh/coronavirus.

Definition.

Whenever the term "symptom" or "*COVID-19 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.

II. Face-Coverings/Masks:

To help prevent the spread of droplets containing COVID-19, all County residents and visitors are strongly recommended to wear face coverings in accordance with and as required by the Guidance for the Use of Face Coverings issued by CDPH, effective March 1, 2022. The Guidance is attached herein as Attachment "**A**" and can be found at:

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

Masks are required for all individuals in the following indoor settings, regardless of vaccination status:

- Public Transit and in transportation hubs- Masks guidance/requirement is subject to Federal Requirements and guidance found at https://www.cdc.gov/coronavirus/2019-ncov/travelers/face-masks-public-transportation.html Examples: airplanes, ships, ferries, trains, subways, buses, taxis, and ride-shares) and in transportation hubs (examples: airports, bus terminals, marina, train station, seaport or other port, subway station, or any other area that provides transportation).
- Emergency shelters and cooling and heating centers.
- Healthcare settings (applies to all healthcare settings, including those that are not covered by State Health Officer Order issued on July 26, 2021).
- Local correctional facilities and detention centers.
- Long Term Care Settings & Adult and Senior Care Facilities.

NOTE: In workplaces, employers are subject to the Cal/OSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in

some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard and should consult those regulations for additional applicable requirements.

NOTE: In accordance with State Health Officer Order, issued on July 26, 2021, and found at 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, in certain healthcare situations or settings, surgical masks are required.

No person shall 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 this mask order:
  - Persons younger than two years old.
  - 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.

III. **Health Care Workers COVID-19 Vaccine Requirement Order**:

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 February 22, 2022, 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:

B: 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

o. 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.

IV. Requirements and Guidance for Specific Facilities

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, issued on July 26, 2021 and 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:

C: 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

1. **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:

D: 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.

2. **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:

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

3. **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 dose requirements as set forth in the February 22, 2022, 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:

F: 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.

4. **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 issued 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:

G. 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. **Self-quarantine of Persons Exposed to COVID-19**

   - If you are known to be exposed to COVID-19 (regardless of vaccination status, prior disease, or occupation), it is strongly recommended to follow CDPH Quarantine guidance found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx.

   - **K-12 Schools and Child Care**

     - Schools/school districts are advised to follow CDPH COVID-19 Public Health Guidance for K-12 Schools in California, 2021-2022 School Year found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/K-12-Guidance-2021-22-School-Year.aspx

     - Child care providers and programs are advised to follow CDPH Guidance for Child Care Providers and Programs found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Child-Care-Guidance.aspx.

   - **Workplaces**

     - In workplaces, employers and employees are subject to the Quarantine requirement as stated in the CalOSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard.

Exposed to COVID-19 or exposure to COVID-19 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.

2. **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.

3. **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. 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.

   CDC Guidance can be found at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html

4. **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.

5. **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) remain up-to-date as defined by CDC with COVID-19 vaccination. CDC Guidance can be found at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html

6. 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 March 23, 2022, the County has reported a total of 546,125 recorded confirmed COVID-19 cases and 6,857 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. The CDPH issued a revised Guidance for the Use of Face Coverings, effective March 1, 2022, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

8. 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

9. 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 or boosted; (ii) there is limited supply of therapeutic options for high-risk individuals who have a high risk of exposure to COVID-19 or have mild-moderate COVID-19 infection; (iii) the current consensus among public health officials for slowing down the transmission of and avoiding contracting COVID-19 is for at-risk persons to complete a COVID-19 vaccination series and receive a booster if eligible, wear well-fitted mask in indoor settings when around others outside of their household, practice distancing, frequently wash hands with soap (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 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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: March 24, 2022

Regina Chinsio-Kwong, DO
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 May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Authorize and Direct Execution of Amendments to CalOptima's Primary and Secondary Agreements with the California Department of Health Care Services

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 (Chairman) to execute Amendments extending the termination dates of the Primary Agreement and Secondary Agreement between the California Department of Health Care Services (DHCS) and CalOptima.

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 December 2016, CalOptima entered into a new four (4) year agreement with the California Department of Health Care Services (DHCS) for the Primary and Secondary Agreements. Amendments to these agreements are summarized in the attached appendix, including Amendment 54, which extends the Primary Agreement to December 31, 2022 and Amendment 12, which extends the Secondary Agreement to December 31, 2022. The Primary Agreement contains among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

Extension of the Termination Dates of the Primary and Secondary Agreements
On March 30, 2022, DHCS requested CalOptima's acceptance to extend the termination date of CalOptima's Primary and Secondary Agreements from the current termination date of December 31, 2022 to December 31, 2023.

In order to be prepared to execute extensions to the Primary and Secondary Agreements, staff is requesting that the Board provide authority and direction to the Chair to execute amendments extending the Primary and Secondary Agreements to December 31, 2023. The amendments do not contain any rate changes or otherwise set any rates. Staff anticipates receiving final Calendar Year (CY) 2023 rates from the DHCS later in CY 2022 and will subsequently request authority from the Board to authorize and direct the Chairman to execute such amendments. If the amendments to the Primary and Secondary Agreements are not consistent with Staff's understanding as presented in this document or if they include substantive and unexpected language changes, staff will return to the Board for subsequent consideration.

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Fiscal Impact

The recommended action is a budgeted item with no additional fiscal impact in the current fiscal year. Staff will include funding for the extended contract period of January 1, 2023, through December 31, 2023, in the Fiscal Year 2022-23 and future operating budgets.

Rationale for Recommendation

CalOptima's extension of the Primary and Secondary Agreements with DHCS are necessary for the continued operation of CalOptima's Medi-Cal program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1_Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Hunn — *04/28/2022*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 5

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

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

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
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

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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

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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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Authorize and Direct Execution of an Amendment to Agreement 16-93274 ("Care Coordination Agreement") with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

Contact

Carmen Dobry, Executive Director of Compliance, (657) 235–6997

Recommended Action

Authorize and direct the Chairman of the Board of Directors ("Chairman") to execute Amendment 06 to the Care Coordination Agreement between CalOptima and the California Department of Health Care Services (DHCS) in order to continue operation of the OneCare Program.

Background

As a County Organized Health System ("COHS"), CalOptima contracts with 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 Primary Agreement with the DHCS. Amendments to this Primary Agreement are summarized in the attached appendix, including Amendment 54, which extends the agreement through December 31, 2022. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA) compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary Agreement and placed it in the standalone Care Coordination Agreement. The Chairman executed the Care Coordination Agreement, an action that was ratified during the August 2016 Board meeting. Subsequently, the Chairman has executed five amendments to the Care Coordination Agreement pursuant to Board authority. The Care Coordination Agreement is set to terminate on December 31, 2022. The Care Coordination Agreement contains no payment rates.

Discussion

Amendment to Agreement 16-93274 ("Care Coordination Agreement")

On March 18, 2022, DHCS provided managed care plans ("MCPs"), including CalOptima, with a draft amendment to extend the Care Coordination Agreement through December 31, 2023.

The Centers for Medicare & Medicaid Services ("CMS") requires that plans renewing their D-SNP programs submit evidence of a MIPPA-compliant Medicaid contract for the 2022 contract year no later than July 1, 2022. Executing Amendment 06 to the Care Coordination Agreement is required in order for CalOptima to meet CMS's filing requirements and to continue operating CalOptima's D-SNP (OneCare) in contract year 2023. CalOptima has requested that DHCS send the final amendment to

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CalOptima as soon as possible in order to allow for immediate signature by CalOptima and prompt return to DHCS for counter-signature.

The Amendment 06 contains language changes in addition to the extension of the expiration date. DHCS has only shared boilerplate contract amendments with CalOptima at this time. If the final contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board for further consideration. Please see Attachment 3 "Additional CY 2023 Agreement 16 – 93274 Detail" for further information regarding the language changes contained within the Care Coordination Agreement.

Fiscal Impact
The recommended action is projected to be budget neutral.

Rationale for Recommendation
CalOptima's execution of Amendment 06 to the Care Coordination Agreement with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare program during 2023.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1_Appendix summary of amendments to Agreements with DHCS
2. Attachment 2_ 2023 Draft Amendment to Agreement 16-93274
3. Attachment 3_Additional CY 2023 Agreement 16 – 93274 Detail

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 6

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

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

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
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

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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

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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

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Exhibit A
SCOPE OF WORK

Exclusively Aligned Enrollment Dual Eligible Special Needs Plan

1. Service Overview

This contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP), <INSERT D-SNP LEGAL ENTITY NAME>.

This D-SNP Contract is a care coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including those benefits not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates and when Medi-Cal benefits are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

2. Project Representatives

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

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division (MCOD) Attn: Chief, Managed Care Systems and Support Services Branch	California Attn:, President
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Email:

B. Direct all inquiries to:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Contracting Officer	California Attn: President
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Email:

C. Either party may make changes to the information above by giving written

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Exhibit A
SCOPE OF WORK

notice to the other party. Said changes shall not require an amendment to this D-SNP Contract.

3. See the following attachments for a detailed description of the services to be performed:
   A. Exhibit A: Care Coordination
   B. Exhibit X

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

1. Care Coordination and Integration

This D-SNP Contract is a care coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including when Medi-Cal benefits are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. Without limitation, D-SNP shall coordinate care with providers and other entities for the Medi-Cal benefits outlined in Exhibit H, when Medically Necessary for the Member. D-SNP Contractor must notify Members that D-SNP Contractor, and not the Member, is responsible for coordination of the Member's Medi-Cal benefits.

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

ii. For coordination of In-Home Supportive Services (IHSS) benefits, Contractor's D-SNP will contact the County IHSS Office. County IHSS Office contact information can be found at https://www.cdss.ca.gov/inforesources/county-ihss-offices; and

iii. For coordination of Medi-Cal Dental benefits, Contractor's D-SNP will contact the DHCS Dental Administrative Service Organization (ASO) for provider information and the coordination of dental benefits. ASO contact information can be found at the following link: https://smilecalifornia.org/contact-us/.

iv. For coordination of Medi-Cal pharmacy benefits, Contractor's D-SNP will contact Medi-Cal Rx, and contact information can be found at the following link: https://medi-calrx.dhcs.ca.gov/home/contact.

A. D-SNP Contractor must additionally comply with state-specific care coordination requirements, which are fully outlined in the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

These state-specific requirements include:

1) Incorporating Medi-Cal data into the D-SNP risk stratification process;
2) Incorporating Medi-Cal services and providers into the development

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and execution of the member's care plan and care team, including Medi-Cal services accessed through the aligned Medi-Cal plan as well as Fee-For-Service and other Medi-Cal delivery systems (including home- and community-based waiver programs);
3) Incorporating dementia care specialists in care teams; and
4) Utilizing Long-Term Services and Supports liaisons in supporting care transitions.

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

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

C. Information Sharing
1) D-SNP Contractor is responsible for complying with state policy implementing Centers for Medicare & Medicaid Services integration standards for D-SNP plans.
2) In 2023, D-SNPs must require their contracted hospitals and SNFs to use an electronic process to inform D-SNPs and MCPs in a timely manner of any Medicare-covered hospital or SNF admissions for all members. The goal of this policy is for D-SNPs and MCPs to be notified of all Medicare hospital and SNF admissions simultaneously and timely.
3) D-SNPs and MCPs will then be expected to coordinate care management for their members and facilitate member access to needed LTSS services to support care transitions.
4) D-SNPs should work with contracted hospitals and SNFs to prioritize timely notifications.
5) State guidance on this "Information Sharing Policy" will be provided through CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

D. D-SNP Contractor is responsible for providing integrated member materials to members, which are fully outlined in the CalAIM Dual Eligible

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Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

Required integrated member materials will include:

1) Annual Notice of Change (ANOC)
2) Evidence of Coverage (EOC)
3) Summary of Benefits
4) ID Card
5) Provider/Pharmacy directory
6) Formulary
7) Single member services/customer service phone number for members to contact the plan regarding their Medicare or Medi-Cal plan and benefits

D-SNP Contractor will be required to make all integrated member materials available in the threshold languages for their aligned MCP service area. This will include those languages that meet the more stringent of either (1) Medicare's five (5) percent threshold for language translation; or (2) DHCS' prevalent language requirements (the DHCS threshold and concentration standard languages), as specified in annual guidance to Contractors on specific translation requirements for their service areas.

E. Interoperability Requirements for Member Records
    1. D-SNP contractor will be required to have a single Application Programming Interface (API) for members to access both Medicare and Medi-Cal information.

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4. Supplemental Benefits

Using Medicare rebate dollars, D-SNP Contractor is required to provide the following supplemental benefits to Members:

1) $0 copay for one (1) routine eye exam every year
2) Every two years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses

5. Quality and Data Reporting

D-SNP Contractor is responsible for reporting quality measures to the Department of Health Care Services (DHCS), which are fully outlined in the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-

SNP%29-Contract-and-Program-Guide.aspx.

This reporting will include:

1) Selected HEDIS measures, calculated at the PBP level for the PBPs included in this contract;
2) State-specific care coordination and long-term services and supports process measures; and
3) State-specific dementia measures.

6. Consumer Participation in Governance Boards

The Contractor shall ensure consumer participation in governance boards that will provide regular feedback to the Contractor's governing board on issues of plan management and Enrollee care. The Contractor shall ensure that the committee:

1) Meets at least quarterly throughout the plan year.
2) Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the D-SNP population, including individuals with disabilities.

D-SNP Contractor is responsible for reporting their committee charter and membership to CMS and DHCS. CMS and DHCS reserve the right to review and approve Enrollee membership. The Contractor can engage D-SNP enrollees in existing committees.

7. All Plan and Policy Letters

In addition to the terms and conditions of this Contract, D-SNP Contractor shall comply with state-specific departmental guidance in the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

To the extent that state guidance conflicts with Medicare requirements or regulations, the D-SNP Contractor shall comply with Medicare requirements and regulations. For purposes of this Provision, state guidance shall conflict with Medicare requirements or regulations only to the extent that the state guidance requires conduct that would violate Medicare requirements or regulations.

8. Coverage Area and Eligible Beneficiaries

Members covered under this Contract shall include all Dual Eligible Members who are enrolled in the EAE D-SNP <INSERT PBP NUMBERS>. Contractor may enroll the following populations:

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1) Full-benefit dually eligible beneficiaries (QMB+, SLMB+ and Other Full Benefit Dually Eligible Beneficiaries) who are also enrolled (or will be enrolled) in the Medicaid plan affiliated with owned by the same parent organization as the Contractor's DSNP, <INSERT NAME OF AFFILIATED MEDI-CAL PLAN>, and who reside in the following county or counties to maximize the continuum of services available through both Medicare and Medi-Cal:

   XX County

The Contractor agrees to conduct enrollment of Eligible Persons in accordance with the policies and procedures set forth in this contract and maintain exclusively aligned enrollment for the duration of the contract period.

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9. Certification and Enrollment Reporting

A. D-SNP Contractor shall submit to DHCS a certification, signed by the Chief Operations Officer or similar executive officer, that attests to the number of Members enrolled in Contractor's D-SNP as of the effective date of this Contract.

B. By the fifth working day of each month during the term of the D-SNP Contract, D-SNP Contractor shall submit a report, signed by the Chief Operations Officer or similar executive officer, to DHCS summarizing the previous month's Enrollment numbers.

C. Additional guidance on Contractor enrollment responsibilities will be fully outlined in the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

10. Member Billing Prohibitions

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

Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.

B. A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements shall specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill Medi-Cal or the Member's Medi-Cal MCP as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal. D-SNP Contractor's provider agreements shall require a contracted Medicare provider to comply with Welfare and Institutions Code Section 14019.4.

11. Provider Network Requirements

A. D-SNP Contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. The California Health and Human Services Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-calfee-for-service-ffs-providers. Alternatively, D-SNP Contractor can obtain the file from the affiliated Medi-Cal plan.

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

C. D-SNP Contractor will also comply with additional network guidance fully outlined in the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. This guidance will include:

1) Upon execution of this D-SNP Contract and annually thereafter, D-SNP Contractor shall submit to DHCS a report that outlines D-SNP Contractor's full Medi-Cal provider network within the defined Service Area.

2) D-SNP Contractor will also be responsible for meeting network adequacy and aligned network requirements as detailed in CalAIM D-SNP Policy Guide issued by DHCS.

3) D-SNP Contractor must comply with additional state-specific

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continuity of care protections for members, including:

- 12-month continuity of care period for primary and specialty providers with whom the member has a pre-existing relationship and who are willing to work with the D-SNP; and
- Access to medically necessary Medicare-covered Durable Medical Equipment and medical supplies. In addition to complying with Medicare continuity of care requirements for these services and providers as outlined in 42 CFR 422.100(l)(2)(iii), EAE D-SNPs must comply with requirements outlined in the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx

12. Medi-Cal and Medicare Eligibility Verification

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

1) Confirm Medicare Advantage and Medi-Cal eligibility;

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

B. D-SNP Contractor must validate Medicare Advantage and Medi-Cal eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces.

1) Medicare and/or Medi-Cal eligibility systems will indicate whether a beneficiary is currently enrolled or is pending enrollment in a Medi-Cal MCP at the time of the inquiry.

2) If the beneficiary meets the criteria for enrollment listed in Section *X*, Covered Area and Eligible Beneficiaries the beneficiary may be enrolled in the Contractor's D-SNP.

C. D-SNP Contractor shall ensure appropriate training of plan personnel and contracted providers regarding the use of the Medi-Cal eligibility verification system interface and the interpretation of its eligibility results.

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

13. Enrollments and Disenrollments

Plans should adhere to enrollment and disenrollment processes and communications, as dictated by federal Medicare rules, and supplemented by the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx

14. Medicare Deeming Period

D-SNP Contractor is required to maintain enrollment for Members for at least a three-month deeming period following notification of the Member having lost Medi-Cal eligibility.

15. Contract Term

This D-SNP Contract shall be effective from January 1, 2023 through December 31, 2023.

16. Termination

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

15. Compensation

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

16. Centers for Medicare & Medicaid Services Documentation

D-SNP Contractor shall submit to DHCS a complete and accurate copy of the Medicare Advantage bid for the contract containing the PBPs covered by this contract, as approved by CMS.

If not included in the approved bid, the D-SNP Contractor shall also provide to DHCS the following information, in a format as specified by DHCS, upon execution of this contract, no later than June 30, 2022, and annually thereafter on the last day of June to the Contract Manager:

1) The current approved Model of Care;

2) A list of the Supplemental Benefits included in the initial annual Medicare Advantage bid submission to CMS;

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3) A list of approved Supplemental Benefits.

If D-SNP Contractor offers Supplemental Benefits, those services should be coordinated with the MCP to ensure the D-SNP tracks enrollee use of Supplemental Benefits and exhausts Supplemental Benefits prior to authorization of or referral for Medi-Cal benefits, including any Community Supports that the MCP is approved to offer.

D-SNP Contractor shall submit to DHCS copies of CMS reporting, compliance, and audit findings, as well as Medicare encounter data.

17. Medicare Encounter Data Requirements

D-SNP shall submit electronic records of all encounters, including encounters resulting in zero Medicare claims, monthly, in a mutually agreed upon format. Each encounter record should be specific to the enrollee and Provider, listing all the data elements required for each service. This data will provide DHCS with information on services paid for by Medicare.

Reporting requirements and data elements shall not exceed those mandated by the Centers for Medicare and Medicaid Services (CMS) for Medicare Advantage plans. Additional details are fully outlined in the CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.asp

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

2. AMENDMENT: No amendment or variation of the terms of this Agreement

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

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

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

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

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

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

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

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

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

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

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

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

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

13. COMPENSATION:

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

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

15. ANTITRUST CLAIMS:

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

16. CHILD SUPPORT COMPLIANCE ACT:

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

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

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

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

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

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

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

D. D-SNP Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR 60, “Office of the Federal Contract Compliance

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

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

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

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

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

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by DHCS, D-SNP Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. **Travel and Per Diem Reimbursement**

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

3. **Procurement Rules**

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

4. **Equipment Ownership / Inventory / Disposition**

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

5. **Subcontract Requirements**

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

6. **Income Restrictions**

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

7. **Audit and Record Retention**

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

8. **Site Inspection**

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

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

9. Federal Contract Funds

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

10. Intellectual Property Rights

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

11. Air or Water Pollution Requirements

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

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

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

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

12. Prior Approval of Training Seminars, Workshops or Conferences

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

13. Confidentiality of Information

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

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

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

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

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

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

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

14. Documents, Publications and Written Reports

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

15. Dispute Resolution Process

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

16. Financial and Compliance Audit Requirements

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

17. Human Subjects Use Requirements

By signing this D-SNP Contract, D-SNP Contractor agrees that if any

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

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

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

18. Novation Requirements

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

19. Debarment and Suspension Certification

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

B. By signing this D-SNP Contract, D-SNP Contractor certifies to the best of its knowledge and belief, that it and its principals:

1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

2) Have not within a three (3) year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

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

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

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

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

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

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

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

20. Smoke-Free Workplace Certification

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

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

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

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

21. Covenant Against Contingent Fees

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

22. Payment Withholds

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

23. Performance Evaluation

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

24. Officials Not to Benefit

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

25. Four-Digit Date Compliance

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

26. Prohibited Use of State Funds for Software

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

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

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

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

28. Alien Ineligibility Certification

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

29. Union Organizing

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

30. Contract Uniformity (Fringe Benefit Allowability)

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

31. Lobbying Restrictions and Disclosure Certification

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

A. Certification and Disclosure Requirements

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

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

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

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herein. An event that materially affects the accuracy of the information

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reported includes:

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

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

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

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

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

B. Prohibition

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

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Exhibit E, Attachment 1
DEFINITIONS

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

1. **Care Coordination or Coordination of Care** means a process used by a person or team to assist Members in accessing Medicare and Medicaid services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes.

2. **Centers for Medicare & Medicaid Services (CMS)** means the Federal agency responsible for management of the Medicare and Medicaid programs.

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

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

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

6. **D-SNP Contract** means this written agreement between DHCS and the D-SNP Contractor.

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

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Exhibit E, Attachment 1
DEFINITIONS

8. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and/or Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan. This Contract is only for Full-benefit dually eligible beneficiaries (QMB+, SLMB+ and Other Full Benefit Dually Eligible Beneficiaries).

9. **Enrollment** means the process by which a beneficiary eligible for enrollment as contained in Exhibit A, Attachment 1, Provision 3 becomes a Member of the Contractor's D-SNP.

10. **Exclusively Aligned Enrollment** means DHCS has limited enrollment in a D-SNP to full-benefit dual eligible individuals who are enrolled in a D-SNP for their Medicare benefits and a MCP for their Medi-Cal benefits, and the D-SNP and MCP are both owned and controlled by the same parent organization.

11. **Facility** means any premise that is:

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

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

12. **Medi-Cal Managed Care Health Plan (MCP)** means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services. For the purposes of this contract, this includes subcontracted delegate health plans. A subcontracted delegate health plan is a health care service plan that is a subcontractor of a Medi-Cal managed care plan that DHCS determines to have assumed the entire financial risk for all Medi-Cal services provided to a dual eligible beneficiary that are covered under the applicable comprehensive risk contract of the Medi-Cal managed care plan.

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

14. **Service Area** means the geographic area in which Members or potential Members reside and for whom D-SNP Contractor is approved to provide services by CMS.

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

16. **Subcontracted Delegate Health Plan** means a health care service plan that is a subcontractor of a Medi-Cal managed care plan that

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Exhibit E, Attachment 1
DEFINITIONS

DHCS determines to have assumed the entire financial risk for all Medi-Cal services provided to a dual eligible beneficiary that are covered under the applicable comprehensive risk contract of the Medi-Cal managed care plan.

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

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

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

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

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

C. All existing Policy Guidance issued by DHCS, MMCD, or the current Managed Care Operations Division (MCOD) can be viewed at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx and shall be complied with by D-SNP Contractor. All Policy Guidance issued by DHCS subsequent to the effective date of this D-SNP Contract shall

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

2. Entire Agreement

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

3. Amendment Process

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

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

4. Change Requirements

A. General Provisions

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

B. D-SNP Contractor's Obligation to Implement

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

5. Delegation of Authority

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

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

6. Authority of the State

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

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

7. Fulfillment of Obligations

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

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

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

9. Prohibition Against Novations

D-SNP Contractor and DHCS shall not enter any novation agreements. Contractor shall not propose any novation agreements nor shall DHCS agree to or act upon any proposal.

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

10. Obtaining DHCS Approval

D-SNP Contractor shall obtain written approval from DHCS prior to commencement of operation under this D-SNP Contract:

A. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS pursuant to this Provision.

B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision shall not be construed to imply DHCS approval of any material that has not received written DHCS approval.

11. Program

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

12. Certifications

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

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

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

13. Notices

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

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

California
Attn: President
CA

14. Term

The D-SNP Contract will become effective January 1, 2023, and will continue in full force and effect through December 31, 2023.

15. Service Area

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

All D-SNP Contract provisions apply separately to each Service Area.

16. D-SNP Contract Extension

DHCS may extend this D-SNP Contract for any reason.

17. Termination for Cause and Other Terminations

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

A. Termination - State or Director

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

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

B. Termination for Cause

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

2) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the D-SNP Contract, the D-SNP Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination. Except for termination pursuant to this Paragraph B, item 3) below, D-SNP Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 19, Disputes. Termination of the D-SNP Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides D-SNP Contractor with at least 60 calendar days' notice of termination. The termination of this D-SNP Contract shall be effective on the last day of the second full month from the date of the notice of termination. D-SNP Contractor agrees that 60 calendar days' notice is reasonable.

3) DHCS may terminate this D-SNP Contract in the event that D-SNP Contractor enters negotiations to change ownership or actually changes ownership, enters negotiations to assign or delegate its duties and obligations under the contract to another party or actually assigns or delegates its duties or obligations under the D-SNP Contract.

C. Termination - D-SNP Contractor

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

D. Termination of Obligations

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

18. Disputes

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

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

A. Disputes Resolution by Negotiation

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

B. Notification of Dispute

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

2) D-SNP Contractor's notification will state, on the basis of the most accurate information then available to D-SNP Contractor, the following:

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

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

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

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

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

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

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g) D-SNP Contractor's desired remedy.

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

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

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

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

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

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

Contractor of all claims in accordance with Paragraph F, Waiver of Claims, below.

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

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

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

j) D-SNP Contractor Duty to Perform

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

k) Waiver of Claims

If D-SNP Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required

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information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 19, Disputes, that failure shall constitute a waiver by D-SNP Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

19. Audit

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

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

A. Books and Records

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

B. Records Retention

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

20. Inspection Rights

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

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

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

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

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of D-SNP Contractor's primary care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

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

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

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are being performed.

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

21. Confidentiality of Information

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

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

   D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. D-SNP Contractor is not required to report requests for Medical Records made in accordance with applicable law. Exhibit G is hereby incorporated into this contract by reference.

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

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

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

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

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

22. Third-Party Tort and Workers' Compensation Liability

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

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

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

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

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

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

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

D. If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor shall refer the request to the Third Party Liability and Recovery Branch with the

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information contained in Paragraph B above, and shall provide the name, address and telephone number of the requesting party.

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E. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding D-SNP Contractor's service and utilization information, and paid invoices and claims submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the secure file transfer protocol folders.

23. Records Related To Recovery for Litigation

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

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

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

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

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

24. Equal Opportunity Employer

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

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copies of the notice in conspicuous places available to employees and applicants for employment.

25. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor shall not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor's D-SNP on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56 in accordance with the statues identified in Exhibit E, Attachment 2, Provision 26 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this D-SNP Contract, discrimination may include, but is not limited to, the following:

1) Denying any Member any Covered Services;

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

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

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

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

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

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

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

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

D-SNP Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. D-SNP Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member's health.

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26. Federal and State Nondiscrimination Requirements

D-SNP Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. D-SNP Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing regulations.

27. Discrimination Grievances

D-SNP Contractor shall process a grievance for discrimination as required by APL 21-004, and in accordance with federal and State nondiscrimination law as stated in 45 CFR sections 84.7; 34 CFR section 106.8; 28 CFR section 35.107; and W&I Code section 14029.91(e)(4).

A. D-SNP Contractor shall designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements, and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. D-SNP Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination grievances by D-SNP Contractor. D-SNP Contractor shall not require a Member or potential enrollee to file a discrimination Grievance with D-SNP Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor shall submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights:

1) The original discrimination grievance;

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2) The provider's or other accused party's response to the discrimination grievance;

3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on behalf of D-SNP Contractor;

4) Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance;

5) All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the discrimination grievance acknowledgment letter and resolution letter; and

6) The results of D-SNP Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

28. Nondiscrimination Notice and Language Taglines

A. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in a conspicuously visible font size in English, the threshold languages, and at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted as required in APL 21-004 and in accordance with 42 CFR section 438.10(d)(2)-(3) and W&I Code sections 14029.91(f) and 14029.92(c).

B. D-SNP Contractor's nondiscrimination notice shall include all information required by W&I Code section 14029.91(e) and APL 21-004, any additional information required by DHCS, and shall provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation or identification with any other persons or groups defined in Penal Code

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422.56. (W&I Code section 14029.91(e); H&S Code section 11135).

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (W&I Code section 14029.91(e)).

29. Disabled Veteran Business Enterprises (DVBE)

D-SNP Contractor shall comply with applicable requirements of California law relating to DVBE commencing at Section 10115 of the Public Contract Code.

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30. Word Usage

Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

31. Federal False Claims Act Compliance

Effective January 1, 2007, D-SNP Contractor shall comply with 42 USC Section 1396a (a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this D-SNP Contract. Upon request by DHCS, D-SNP Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

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Exhibit G
BUSINESS ASSOCIATE ADDENDUM

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. D-SNP Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement

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on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

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9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a

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confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible,

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Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS

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Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incindent-Report-PIR.pdf.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request

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approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, D-SNP Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

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20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement

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and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

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

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22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

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

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Additional CY 2023 Agreement 16 – 93274 Detail

Section/Provision:	PDF page	Updates to Provision:
Exhibit A - SCOPE OF WORK		
1. Service Overview	Page 1	• Clarifies language to explicitly reiterate the D-SNP is responsible for coordination of all Medi-Cal and Medicare benefits, including Medi-Cal benefits that are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems.
1. Care Coordination and Integration	Pages 3-5	• Modifies language for who to contact for care coordination of the different types of services (BH, IHSS, Denti-Cal, Medi-Cal Rx). • Adds new language to reference additional guidance in **DHCS D-SNP Policy Guide** for: ▸ (provision A) State-specific Care coordination requirements ▸ (provision C) Information Sharing to require contracted hospitals and SNFs to use an electronic process for timely notifications of Medicare-covered hospital or SNF admissions, to facilitate timely care coordination and access to LTSS services to support care transitions. ▸ (provision D) Adds new language to reference seven (7) required integrated materials (*ANOC, EOC SB, ID card, Directory, Formulary*), including a single member services phone number. Also specifies a requirement to follow the more stringent criteria for determining material threshold languages. • Adds new language (provision E) for Intereoperability requirements for Member Records.
4. Supplemental Benefits	Page 5	• New provision to require the use of Medicare rebate dollars to provide vision as a supplemental benefits and defines the coverage of: 1) $0 copay for one (1) routine eye exam every year. 2) Every two years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses.
5. Quality and Data Reporting	Pages 5-6	• New provision added to reference additional guidance in DHCS D-SNP Policy Guide for: 1) Selected HEDIS measures, calculated at the PBP level for the PBPs included in this contract; 2) State-specific care coordination and long-term services and supports process measures; and 3) State-specific dementia measures.
6. Consumer Participation in Governance Boards	Page 6	• New provision added to require consumer participation in governance boards and ensuring the committee:

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		1) Meets at least quarterly throughout the plan year. 2) Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the D-SNP population, including individuals with disabilities. • Requires the reporting of committee charter and membership to CMS and DHCS. CMS and DHCS reserve the right to review and approve Enrollee membership. The D-SNP can engage D-SNP enrollees in existing committees.
7. All Plan and Policy Letters	Page 6	• Modifies language to require compliance with D-SNP Policy Guide, to replace the previously referenced All Plan Letters.
8. Coverage Area and Eligible Beneficiaries	Pages 6- 7	• Updates language to clarify enrollment of full-benefit dually eligible beneficiaries and maintaining exclusively aligned enrollment.
9. Certification and Enrollment Reporting	Page 7	• Clarifies language to remove previously referenced All Plan Letters. • References additional guidance to come in D-SNP Policy Guide.
11. Provider Network Requirements	Page 8-9	• New provision (provision C) added to reference additional guidance in DHCS D-SNP Policy Guide for: 1) Network reporting 2) Network adequacy and Aligned network standards 3) Continuity of Care
12. Medi-Cal and Medicare Eligibility Verification	Page 9	• Clarifies language to delete references to Cal MediConnect. • Clarifies language to ensure appropriate training of Plan staff and contracted providers to use Medi-Cal eligibility verification systems.
13. Enrollment/Disenrollment	Page 10	• New provision added to reference guidance in DHCS D-SNP Policy Guide as a supplement to enrollment and disenrollment processes required by federal Medicare rules.
14. Medicare Deeming Period	Page 10	• New provision to require a minimum 3-month deeming period following notification of the Member having lost Medi-Cal eligibility.
15. Contract Term	Page 10	• Modifies the contract term to be defined as only for 2023 - 1/1/23-12/31/23.
16. Centers for Medicare and & Medicaid Services Documentation	Pages 10-11	• Updates the language to incorporate reference to Community Supports.
17. Medicare Encounter Data Reporting	Page 11	• New provision added to require monthly submission of Medicare encounter data to DHCS to provide DHCS information on services paid for by Medicare, as well as

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		reference additional guidance in DHCS D-SNP Policy Guide.
Exhibit E, Attachment 1 Definitions		
Definitions	Pages 29-31	• Updates language throughout section to remove references to the Coordinated Care Initiative (CCI) and Cal MediConnect, revise existing definitions, as well as adds new terms, such as: ▸ Exclusively Aligned Enrollment ▸ Subcontracted Delegate Health Plan
Exhibit E, Attachment 2 PROGRAM TERMS AND CONDITIONS		
1. Governing Law	Page 32	• Modifies language to incorporate reference to D-SNP Policy Guide.
10. Obtaining DHCS Approval	Page 36	• New provisions added (provisions A & B) to define the timelines DHCS will follow to review any materials for D-SNP use.
17. Terminations for Cause and Other Terminations	Page 38	• Removes language that is already contained in other provisions.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Authorize and Direct Execution of the Cal MediConnect Three-Way Agreement Between CalOptima, the California Department of Health Care Services and the Centers for Medicare & Medicaid Services

Contact

Carmen Dobry, Executive Director, Compliance, (657) 235-6997

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute a new three-way agreement (Agreement) between CalOptima, the California Department of Health Care Services (DHCS), and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program in order to continue operation of the OneCare Connect program for the remainder of 2022.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect, a Medicare-Medicaid Plan (MMP)) beneficiaries in Orange County. The Board authorized execution of the agreement at its December 5, 2013 meeting. On August 6, 2015, the Board ratified an amendment to the agreement, summarized in **Attachment 1** for amendment A-01. On September 7, 2017, the Board authorized execution of a*new* agreement, to replace the prior agreement in its entirety and served to extend the agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule). On December 7, 2017, the Board authorized execution of a new agreement, to replace the prior agreement in its entirety that served to remove language pertaining to In-Home Supportive Services (IHSS) and other regulatory updates. On October 3, 2019, the Board authorized execution of a new agreement, to replace the prior agreement that incorporates an extension of the program for additional demonstration years (DY) 6 through 8 (through the end of 2022), new provisions and other regulatory updates.

Discussion

On March 28, 2022, the CMS Medicare-Medicaid Coordination Office (MMCO) provided MMPs with a redlined draft contract (**Attachment 2**), for a two-week comment period for Plan's review and feedback. The vast majority of edits to the Agreement reflect regulatory provisions that took effect in January 2022 and are not anticipated to impact MMPs in a negative way.

The overall Agreement updates are related to:

1. Medicare Final Rule regulations that went into effect in 2022;
2. Medicaid regulations that went into effect through CalAIM (i.e. adding Community Supports as applicable to Cal MediConnect, removal of the Multipurpose Senior Services Program (MSSP) as a demonstration benefit as that is now a carve-out from the Medi-Cal and Cal MediConnect Plans); and
3. Removal of the six-month enrollment moratorium prior to the end of the demonstration, which will allow enrollment into Cal MediConnect through 12/1/22.

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A more detailed description of all the redlined revisions is included in **Attachment 3**.

Upon receipt of the redline version of the Agreement on March 28, 2022, CalOptima staff reviewed changes in the requirements and did not have comments nor feedback for CMS/DHCS. Based on review by CalOptima's departments primarily impacted by these provisions, staff does not anticipate any major challenges with meeting the new requirements.

On April 7, 2022, CMS and DHCS held a conference call with all the MMPs in California to discuss significant questions or comments MMP plans had on the redlined changes to the Agreement. CMS verbally announced that it was working to effectuate this new three-way agreement as soon as possible because some of the provisions were effective for 2022. While CMS did not indicate a definitive effective date, CMS indicated it was aiming for a potential May 1, 2022 effective date.

CalOptima is pending receipt of the final version of the new Agreement for signatures. CalOptima staff shared with CMS and DHCS that CalOptima would not be able to provide signature until after the CalOptima Board reviews and authorizes execution of the new Agreement at the May 5, 2022 meeting, and will execute the Agreement shortly thereafter. Given the timing of the receipt of the redlined Agreement in late March, CalOptima staff was not able to present the new Agreement to the Board at an earlier Board meeting. As noted earlier, CMS intends to issue the final version of the Agreement for signature with a potential May 1, 2022 effective date. The issuance of the Agreement with a retroactive effective date of May 1, 2022, will be similar to the three-way agreements the Board executed on September 7, 2017, with an effective date of August 22, 2017 as well as on October 3, 2019, with an effective date of September 1, 2019.

CalOptima staff will evaluate the final Agreement to determine whether any subsequent policy and procedure (P&P) changes are needed to align with requirements in the new Agreement. To the extent that CalOptima staff must revise or create P&Ps that require Board approval, staff will return to the Board at a later date for further consideration and/or ratification of staff recommendations and/or action on these P&Ps.

Fiscal Impact

The recommended action to execute the new Agreement includes the following fiscal provisions: (i) addition of community supports requirements, including payment requirements under Cal MediConnect; (ii) revision to capitated rate structure to include three risk adjustment categories for demonstration year 8; and (iii) addition of Health Network provider reimbursement under the Directed Payment Initiative and in compliance with the COVID-19 Vaccination Incentive Program. Staff has included projected revenue and expenses for the period of January 1, 2022, through June 30, 2022, in the current Fiscal Year (FY) 2021-22 Operating Budget and will include revenue and expenses for the period of July 1, 2022, through December 31, 2022, in the upcoming FY 2022-23 Operating Budget.

The recommended action to incorporate non-fiscal contractual updates is expected to be budget neutral to CalOptima.

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Rationale for Recommendation

CalOptima's execution of the new Agreement with DHCS and CMS is necessary to ensure compliance with the requirements and for the continued operation of CalOptima's Cal MediConnect (OneCare Connect) program through December 31, 2022. Additionally, the CalOptima FY 2021-22 Operating Budget was based on the anticipated rates. Therefore, execution of the Agreement will ensure revenues, expenses and cash payment are consistent with the approved budget.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1- Summary of amendments to the Agreement with DHCS and CMS for Cal MediConnect.
2. Attachment 2 - Redlined Three-Way Contract Agreement
3. Attachment 3 - Description of all the redlined revisions to the Agreement

/s/ Michael Hunn *04/28/2022*

Authorized Signature **Date**

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ATTACHMENT 1 TO AGENDA ITEM 7

The following is a summary of amendments to the three-way agreement approved by the CalOptima Board to date:

Amendments to Agreement	Board Approval
A-01 provided modifications to the contract in anticipation of the July 1, 2015 effective date for voluntary enrollment to: 1. Correct a Knox-Keene Act provision that does not apply to CalOptima related to the IMR process through DMHC. 2. Update to Medicare appeals process and timeframes that CMS will include in all MMP contracts throughout the State.	August 5, 2015
New three-way agreement (Agreement), to replace prior agreement in its entirety Extends the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).	September 7, 2017
New three-way agreement (Agreement), to replace prior agreement in its entirety Removal of language pertaining to In-Home Supportive Services (IHSS) and incorporates other regulatory updates.	December 7, 2017
New three-way agreement (Agreement), to replace prior agreement in its entirety Extends the Agreement for an additional three (3) years to December 31, 2022, additional Demonstration Years (DY) 6 through 8, and incorporates new provisions and other regulatory updates.	October, 3, 2019
New three-way agreement (Agreement), to replace prior agreement in its entirety Incorporates new provisions stemming from CalAIM and the CMS Final Rule regulatory updates, as well as modifies current provisions to align with DHCS current policy decisions for Cal MediConnect.	Pending

Contract

Between

United States Department of Health and Human Services
Centers for Medicare & Medicaid Services

In Partnership with

California Department of Health Care Services

and

Effective: ~~September 1, 2019~~

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This Contract, effective ~~September 1, 2019~~ is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the state of California, acting by and through the Department of Health Care Services (DHCS) and _____ (the Contractor). The Contractor's principal place of business is _____.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, DHCS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq and California Welfare and Institutions Code § 14000 et seq, designed to work closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income and persons with disabilities;

WHEREAS, a purpose of this Contract is to test a new model of payment and service delivery pursuant to 1115A of the Social Security Act;

WHEREAS, the Contractor is in the business of ensuring access to care needed to improve health and quality of life, and CMS and DHCS desire to purchase services from the Contractor to offer quality, accessible care; improve care coordination among medical care, behavioral health, and long-term services and supports; and further the goals of the *Olmstead* Decision;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and state laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contracted entered into by CMS , DHCS, and the Contractor executed December 18, 2013 and re-executed on January 1, 2018, and September 1, 2019, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract, but that were not imposed upon the Contractor either in the original version of this Contract executed on December 18, 2013, as amended, or under applicable laws or regulations, shall be prospective in nature only (effective ~~September 1, 2019~~).

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

Commented [TKO1]: Flag for update

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1. Definition of Terms

1.1. **Actual Non-Service Expenditures** — The Contractor's actual amount incurred for non-service expenditures, including both administrative and care management costs, for Enrollees during each Demonstration Year. These costs will exclude costs incurred by the Contractor prior to the start of the Demonstration. Any reinsurance costs reflected here will be net reinsurance costs.

1.2. **Actual Service Expenditures** — The Contractor's actual amount paid for Covered Services (as defined in Appendix A) delivered during each Demonstration Year. Actual Service Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk-sharing arrangements, or sub-capitation payments.

1.3. **Adjusted Final Capitation Rate Revenue** — The Adjusted Interim Capitation Rate Revenue with the Minimum Savings Percentages, rather than the County-Specific Interim Savings Percentages, applied. This is determined by multiplying the Adjusted Interim Capitation Rate Revenue by (1- the Minimum Savings Percentage) / (1- the County-Specific Interim Savings Percentage).

1.4. **Adjusted Interim Capitation Rate Revenue** — The Total Capitation Rate Revenue excluding the monthly capitation payments for Medicare Part D services, and any risk adjustment or reconciliation associated with Medicare Part D payments.

1.5. **Adjusted Non-Service Expenditures** — The Contractor's Actual Non-Service Expenditures, adjusted to reflect the following:

1.5.1. At the discretion of the State and CMS, exclusion of any costs, including care management, associated with Medicare Part D services as identified in CMS bid instructions and other guidance;

1.5.2. Exclusion of costs greater than one hundred twenty five percent (125%) of the median cost per member per month across all participating Contractors during the Demonstration Year. Consideration will be given to any Contractor with significant non-typical membership mixes that may cause this exclusion to come into effect;

1.5.3. Exclusion of reinsurance costs (net of reinsurance premiums); and

~~1.5.1.~~1.5.4. Adjustments resulting from CMS and the State's review of the Contractor's non-service expenditures to address any inappropriate or excessive non-service expenditures (including executive compensation

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and stop loss expenditures).

1.6. **Adjusted Service Expenditures** — The Contractor's Actual Service Expenditures, adjusted to reflect the following:

1.6.1. –Exclusion of the net cost of all services provided under Medicare Part D;

1.6.2. –Reductions to reflect any recoveries from other payors outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care. These adjustments shall exclude any adjustments associated with coverage of Medicare Part D services; and

~~1.5.2.~~1.6.3. –Adjustments resulting from CMS and the State review of Contractor reimbursement methodologies and levels to address any excessive pricing.

~~1.6.~~1.7. **Advance Directive** — An individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

1.8. **Adverse Benefit Determination** — (i) The 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; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Contractor, the denial of an Enrollee's request to obtain services outside of the Network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

~~1.7.~~1.9. **Alternative Format** — Provision of **Error! Use the Home tab to apply EnrolleeS to the text that you want to appear here.** information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, braille, large font, audio, video, and information read aloud to the Enrollee by an Enrollee service representative.

~~1.8.~~1.10. **Appeal** — In general, an Enrollee's actions, both internal and external to

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the Contractor requesting review of the Contractor's denial, reduction or termination of benefits or services, from the Contractor. 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 the Contractor of an Adverse Benefit Determination.

~~1.9.~~1.11. **Behavioral Health** — An all-inclusive term referring to mental health services provided through the mental health plan (MHP) or Contractor and substance use disorder services.

~~1.10.~~1.12. **Cal MediConnect** — California's State-specific name for the Capitated Financial Alignment Model Demonstration.

~~1.11.~~1.13. **Cal MediConnect Plan (also, Contractor)** — A health plan or other qualified entity jointly selected by the State and CMS for participation in this Demonstration.

~~1.12.~~1.14. **Cal MediConnect Ombuds Program-** The independent contractor established to safeguard the rights and dignity of all beneficiaries supported by Cal MediConnect. This office will be responsible for assisting and resolving issues that Enrollees may encounter with Cal MediConnect Plans.

~~1.13.~~1.15. **California (or State)** — For purposes of this document, California (or State) is generally used to refer to DHCS, though it may encompass collectively CDA, DHCS, DMHC, and DSS.

~~1.14.~~1.16. **Capitated Financial Alignment Model Demonstration ("the Demonstration")** — A model in which a state, CMS, and a Contractor enter into a three-way Contract, and the Contractor receives a prospective blended capitation payment to provide comprehensive, coordinated care.

~~1.15.~~1.17. **Capitated Financial Alignment Model Memorandum of Understanding (CFAM-MOU)** — For purposes of this Contract, this is a document between CMS and California regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model (signed March 27, 2013). This MOU document details the principles under which CMS and the State plan to implement and operate the Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute this Contract setting forth the terms and conditions of the Demonstration and initiate the Demonstration.

~~1.16.~~1.18. **Capitation Rate** — The sum of the monthly capitation payments (reflecting coverage of Medicare Parts A & B services, Medicare Part D

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services, and Medicaid services, pursuant to Appendix A of this Contract). Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

~~1.17.~~1.19. **Care Coordination** — Delineated through requirements, processes and the care model throughout this Contract, Care Coordination is also detailed in WIC Sections 14182.17(d)(4) and 14186(b).

~~1.18.~~1.20. **Care Coordinator** — A clinician or other trained individual employed or contracted by the PCP or the Contractor who is accountable for providing Care Coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one (1) or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

~~1.19.~~1.21. **Care Plan Option (CPO) Services** — A CPO Service is optional under the beneficiary's Individualized Care Plan (ICP). A CPO Service is designed to only supplement, not replace, the required Medi-Cal services under the beneficiary's Individualized Care Plan (ICP). CPO Services are offered entirely at the Contractor's discretion in accordance with the ICP and are subject to State program guidance.

~~1.20.~~1.22. **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.

~~1.21.~~1.23. **Chronic Mental Disorder** — ~~To be considered to have a Chronic Mental Disorder, the~~ The Enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, to constitute a Chronic Mental Disorder: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilias~~, (m) Gender Identity Disorders~~, (mn) Eating Disorders, (n~~o~~) Impulse Control Disorders Not Elsewhere Classified (o~~p~~) Adjustment Disorders, (p~~q~~) Personality Disorders, or (q~~r~~) Medication-Induced Movement

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Disorders.

1.24. **Community Based Adult Services (CBAS)** — Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.

~~1.22.~~1.25. **Community Supports** — Pursuant to 42 C.F.R. § 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 medically appropriate, cost-effective alternatives to services or setting under the State Plan. Community Supports are optional under the Enrollee's Individualized Care Plan (ICP) for both the Contractor and the Enrollee and must be approved by DHCS.

~~1.23.~~1.26. **Contract** — The ~~participation~~ governing agreement that CMS and DHCS have with a Contractor, including for the terms and conditions necessary for participation ~~pursuant to which a Contractor may participate~~ in this Demonstration.

~~1.24.~~1.27. **Contract Management Team (CMT)** — A group of CMS and DHCS representatives responsible for overseeing the contract management functions outlined in Section 3.1.1 of the Contract.

~~1.25.~~1.28. **Contract Operational Start Date** — The first date on which enrollment into the Contractor's Cal MediConnect coverage is effective.

~~1.26.~~1.29. **Contractor** — An entity approved by CMS and DHCS that enters into a Contract with CMS and DHCS in accordance with, and to meet, the purposes specified in this Contract.

~~1.27.~~1.30. **County Organized Health System (COHS)** — A type of Medi-Cal managed care delivery model in which DHCS contracts with a single health plan created by ~~the~~ a County Board of Supervisors.

~~1.28.~~1.31. **County Social Services Agency** — Local county agency that administers the IHSS program.

~~1.29.~~1.32. **Covered Services** — The set of services to be offered by the Contractor as defined in Appendix A of this Contract.

~~1.30.~~1.33. **Cultural Competence** — Understanding and being able to respond appropriately to values, beliefs, and needs that are associated with the Enrollees' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive

health care and supports and services to persons with congenital or acquired disabilities. A competency based on the premise of respect for the Enrollee and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

1.34. **Data Exchange System (DEX)** — Web-based application used to identify providers who have been revoked from Medicare and terminated from states' Medicaid programs. DEX also provides the ability to search for providers and five percent (5%) or more owners listed in the Social Security Administration Death Master File. Data available in the DEX, including the former Medicare Exclusion Database, were previously housed in a server called TIBCO.

~~1.31.~~1.35. **Department of Aging (CDA)** — In California, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State of California. CDA administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program. CDA certifies CBAS centers for participation in the Medi-Cal Program and provides administrative oversight for the MSSP waiver.

~~1.32.~~1.36. **Department of Health Care Services (DHCS)** — The State department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is also generally referred to as "the State" in this document.

~~1.33.~~1.37. **Department of Managed Health Care (DMHC**) — The State department charged with overseeing health care service plans licensed under the Knox-Keene Act.

~~1.34.~~1.38. **Department of Social Services (CDSS)** — The State department responsible for overseeing and providing social services, including the In Home Support Services (IHSS) program.

~~1.35.~~1.39. **Developmental Disability** – A disability which originates before the individual ~~attains age~~ is 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

~~1.36.~~1.40. **Drug Medi-Cal Benefits** — The substance use disorder Medi-Cal benefits that are listed in Title 22, California Code of Regulations, section 51341.1(d) and Welfare and Institutions Code section 14132.03 .

~~1.37.~~1.41. **Dual-Plan Letter (DPL)** — DPLs convey information or interpretation of changes in policy or procedure at the federal or State levels, and about changes in federal or State law and regulations. DPLs provide instruction to the Contractor on how to implement these changes on an operational basis,

and about how federal or State law affect the way in which they operate, or deliver services to Enrollees. The Department shall notify and consult with stakeholders, including the Contractor, prior to the issuance of a DPL in compliance with the provisions of Welfare and Institutions Code section 14186.4(c).

~~1.38.~~1.42. **Emergency Medical Condition** — A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

~~1.39.~~1.43. **Emergency Services** — Inpatient and outpatient ~~services covered under this Contract~~ Covered Services that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

~~1.40.~~1.44. **Encounter Data** — The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology that are submitted to CMS. This record must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, Privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.

~~1.41.~~1.45. **Enrollee** — Any Medicare-Medicaid eligible individual who is enrolled with the~~a~~ Contractor.

~~1.42.~~1.46. **Enrollee Communications** — Materials designed to communicate Covered Services, policies, processes and/or Enrollee rights to Enrollees. This includes but is not limited to pre-enrollment, post-enrollment, and operational materials.

~~1.43.~~1.47. **Enrollment Broker** — Entity contracted by DHCS through the Health Care Options Program (HCO) which operates to provide information and enrollment assistance to eligible ~~Medicare-Medi-Cal~~MMP beneficiaries.

~~1.44.~~1.48. **Exempt Grievance** — Grievances received by telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.

~~1.45.~~1.49. **External Quality Review Organization** — An independent entity that

contracts with the State and evaluates the access, timeliness, and quality of care delivered by the Contractor to their Enrollees.

~~1.46.~~1.50. **Federally-Qualified Health Center (FQHC)** — An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(a)(2)(C).

~~1.47.~~1.51. **First Tier, Downstream and Related Entity** — An individual or entity that enters into a written arrangement that is acceptable to CMS and DHCS with the Contractor, to provide administrative or health care services to the Contractor under this Contract.

~~1.48.~~1.52. **Geographic Managed Care (GMC) County** — A county in which DHCS contracts with two or more Knox Keene licensed health plans for Medi-Cal managed care.

~~1.49.~~1.53. **Grievance** —~~"~~ 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 Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. A Grievance is filed and decided at the Contractor level. (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 Enrollee's rights as provided for in Appendix B of this Contract). Also called a "Complaint."

~~1.50. **Health Care Options Program (HCO)** — A program within the California Department of Health Care ServicesDHCS which operates as an Enrollment Broker providing enrollment assistance to eligible MMP beneficiaries.~~

~~1.51.~~1.54. **Health Outcomes Survey (HOS)** — Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

~~1.52.~~1.55. **Health Plan Management System (HPMS)** — A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

~~1.53.~~1.56. **Health Risk Assessment** — An assessment tool which identifies primary,

acute, long-term services and supports, and Behavioral Health and functional needs.

~~1.54.~~1.57. **Healthcare Effectiveness Data and Information Set** (**HEDIS)** — Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

~~1.55.~~ **High Risk Enrollee** — For risk stratification purposes, an Enrollee who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact by the Contractor within forty-five (45) calendar days after coverage date. The higher risk Enrollees who should be identified from the fee for service utilization data, include but are not limited to Enrollees who:

~~1.56.~~1.58. ~~Have been on oxygen within the past ninety (90) days,~~

1.58.1. Have been on oxygen within the past ninety (90) days,

~~1.56.1.~~ Have been hospitalized within the last ninety (90) days, or have had three (3) or more voluntary and/or involuntary hospitalizations within the past year related to Behavioral Health illnesses,

1.58.2.

~~1.56.2.~~ Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases),

~~1.56.3.~~1.58.3.

~~1.56.4.~~ Have In Home Supportive Services (IHSS) greater than or equal to one hundred ninety five (195) hours/month,

1.58.4.

~~1.56.5.~~ Are enrolled in the Multipurpose Senior Service Program (MSSP),

1.58.5.

~~1.56.6.~~ Are receiving Community Based Adult Services (CBAS),

1.58.6.

~~1.56.7.~~ Have ESRD, AIDS, and/or a recent organ transplant,

1.58.7.

~~1.56.8.~~ Have been currently being treated for cancer,

1.58.8.

~~1.56.9.~~ Have been prescribed anti-psychotic medication within the past ninety (90) days,

1.58.9.

~~1.56.10.~~ Have been prescribed fifteen (15) or more medications in the past ninety (90) days, or

1.58.10.

1.58.11. Have other conditions as determined by the Contractor, based on local resources.

1.59. **Incentive Arrangement** — Any payment mechanism approved by CMS in accordance with 42 CFR section 438.6(b) under which Contractor may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance with this Contract.

~~1.57.~~1.60. **Indian Enrollee** — An Enrollee who is an Indian (as defined at 25 USC 1603(13),~~ 1603(28),~~ or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.) ~~This includes an Enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or~~

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~~more of four criteria including: is member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native Enrollee~~.

~~1.58.~~1.61. **Indian Health Care Provider** — A health care program operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

~~1.59.~~1.62. **Individualized Care Plan (ICP or Care Plan)** — The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

~~1.60.~~1.63. **Interdisciplinary Care Team (ICT)** — A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Enrollee, that works with the Enrollee to develop, implement, and maintain the ICP.

~~1.61.~~1.64. **In-Home Supportive Services (IHSS)** — Pursuant to Article 7 of California Welfare and Institutions Code (Welf. & Inst. Code) (commencing with section 12300 of Chapter 3, and sections 14132.95, 14132.952, and 14132.956), IHSS is a program that provides in-home care for people who cannot safely remain in their own homes without assistance.

1.65. **Long Term Services and Supports (LTSS)** — A wide variety of services and supports that help eligible beneficiaries meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. 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 California Welfare and Institutions Code section

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14186.1, Medi-Cal covered LTSS includes all of the following:

~~1.1.~~

~~1.61.1.~~ In-Home Supportive Services (IHSS);

1.65.1.

~~1.61.2.~~ Community-Based Adult Services (CBAS);

1.65.2.

~~1.61.3.~~ Multipurpose Senior Services Program (MSSP) services; and

1.65.3.

1.65.4. Skilled Nursing Facility services and subacute care services.

~~1.62.~~1.66. **Low Risk Enrollee** —Enrollee who does not meet the minimum requirements of a High Risk Enrollee.

~~1.63.~~1.67. **Marketing, Outreach, and Enrollee Communications** — ~~Any informational materials targeted to Enrollees that are consistent with the definitions of communication materialsand marketing materials at 42 C.F.R. § 422.2260.~~ Any informational materials for current and prospective **Error! Use the Home tab to apply EnrolleeP to the text that you want to appear here.** that are consistent with the definitions and explanations in the Marketing Guidance for California Medicare-Medicaid Plans.

~~1.64.~~1.68. **Medicaid** — The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof. California's State-specific name for this program is Medi-Cal.

~~1.65.~~1.69. **Medi-Cal Dental** — Adult dental benefits provided through Medi-Cal (California's Medicaid program).

~~1.66.~~1.70. **Medi-Cal Managed Care Behavioral Health Services** — Behavioral Health services specified in ~~the~~ Welfare and Institutions Code section 14132.03 that will be provided by ~~the~~ Contractor.

~~1.67.~~1.71. **Medi-Cal Managed Care Plan** — A health plan directly contracted with ~~the California Department of Health Care Services~~ DHCS to provide Medi-Cal services to eligible beneficiaries.

~~1.68.~~1.72. **Medi-Cal Appeal** — A request for a fair hearing in accordance with California Code of Regulations Title 22, section 51014.1 and Welfare and Institutions Code section 10950.

~~1.69.~~1.73. **Medically Necessary Services** — Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-

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Cal. ~~Per Medicare, s~~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, m~~Medical necessity also 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 ~~the~~ Welfare and Institutions Code section 14059.5.

~~1.70.~~1.74. **Medi-Cal Specialty Mental Health Services** — The Medi-Cal services specified in California Code of Regulations, Title 9, section 1810.247. Specialty mental health services do not include the Medi-Cal Managed Care Behavioral Health Services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor. Specialty mental health services are provided through a MHP, in accordance with California Code of Regulations, Title 9, Chapter 11 of Division 1 and include:

~~1.70.1.~~1.74.1. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

~~1.70.2.~~1.74.2. Psychiatric inpatient hospital services;

~~1.70.3.~~1.74.3. Targeted Case Management;

~~1.70.4.~~1.74.4. Psychiatrist services; and

~~1.70.5.~~1.74.5. Psychologist services.

~~1.71.~~1.75. **Medicare** — Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

~~1.72.~~1.76. **Medicare Advantage** — The Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at 42

C.F.R. Part 422.

~~1.73.~~1.77. **Medicare Appeal** — An Enrollee's request for formal review of an Adverse Benefit Determination of the Contractor in regards to a Medicare service in accordance with Section 2.15.

~~1.74.~~1.78. **Medicare-Medicaid Coordination Office (MMCO)** — Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

~~1.75.~~1.79. **Medicare-Medicaid Enrollee (or Enrollee)** — For the purposes of this Demonstration, an individual who is entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, and enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

~~1.76.~~1.80. **Medicare-Medicaid Plan (MMP)** — A health plan contracted with DHCS and CMS to comprehensively manage the full continuum of Medicare and Medi-Cal benefits for Medicare-Medicaid Enrollees including ~~Long Term Supports and Services~~ LTSS as needed and desired by the Enrollee.

~~1.77.~~1.81. **Mental Health Plan (MHP)** — Pursuant to California Code of Regulations, Title 9 section 1810.226, a MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty Mental Health Services. A MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

~~1.78.~~1.82. **Minimum Data Set (MDS)** — A clinical screening system, mandated by federal law for use in nursing facilities, that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 2.0 for nursing facility residents.

~~1.79.~~1.83. **Multi-Purpose Senior Services Program (MSSP**) — A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement. Effective January 1, 2022, MSSP is no longer administered through Cal MediConnect and will be administered through Medi-Cal fee-for-service.

~~1.80.~~1.84. **Network Provider** — ~~An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor~~ Any Provider or entity that has a Network Provider Agreement with Contractor or Contrator's Subcontractor, and received Medi-Cal funding directly or indirectly to order, refer, or render

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Covered Services under this Contract, or any First Tier, Downstream, or Related Entity, for the delivery of services covered under the Contract. A Network Provider must meet the requirements in Section 2.9.9.1. For purposes of 42 C.F.R. § 438.230, Network Provider is not a Subcontractor, First Tier, Downstream or Related Entity by virtue of the Network Provider Agreement.

1.81.1.85. **Notice of Action (NOA)** — A 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.

1.82.1.86. **Passive Enrollment** — An enrollment process through which an eligible individual is enrolled by DHCS into a Contractor's plan following a minimum sixty (60) day advance notification that includes the opportunity for the Enrollee to choose another plan or opt out prior to the effective date.

1.83.1.87. **Post-Stabilization Care Services** — **Covered** Services related to an Eemergency Mmedical cCondition that are provided after an Enrollee's is Emergency Medical Condition has been stabilized in order to maintain the stabilized condition, and/or under the circumstances described in 42 C.F.R. § 438.114(e). are provided, to improve or resolve the condition.

1.84.1.88. **Primary Care Provider (PCP)** — A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

1.85.1.89. **Privacy Rules** — Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 C.F.R. §§ 431.300 through 431.307, as well as relevant California privacy laws.

1.86.1.90. **Program of All-Inclusive Care for the Elderly (PACE)** — As defined in 42 C.F.R. § 460.6, and authorized under California law at Welfare and Institutions Code section 14591 et seq., PACE is a capitated program for individuals over the age of 55 certified by DHCS for nursing home level of care. PACE organizations cover all Medicare and Medicaid benefits, including medical services and long-term services and support, organizes a comprehensive service delivery system governed by federal regulations, and integrate Medicare and Medicaid financing. PACE is a three-way partnership between the federal Ggovernment, California, and the PACE Organizations.

1.87.1.91. **Provider Network** — A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, Care Coordinators, specialty providers,

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Behavioral Health providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. (See Appendix C of the Contract).

~~1.88.~~1.92. **Readiness Review** — Prior to being eligible to accept Demonstration enrollments, each prospective Contractor selected to participate in the Demonstration must undergo a Readiness Review. The Readiness Review evaluates each prospective Contractor's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Covered Services that are Medically Necessary with Enrollee protections. Only Contractors passing the Readiness Review will participate in the Demonstration. At a minimum, each Readiness Review includes a desk review and a site visit to the prospective Contractor's headquarters.

~~1.89.~~1.93. **Recovery Model** — Framework for Behavioral Health that uses ~~"~~recovery-oriented~~"~~ services in recognition that systems of care should ensure culturally competent care for persons with severe mental illness and substance use disorders in the most appropriate, least restrictive level of care necessary to achieve meaningful outcomes such as health, home, purpose and community, consistent with the system of care as set forth in California Welfare and Institutions Code sections 5802 and 5806. Core practices within recovery-oriented systems include peer support, individual choice and person-driven approaches. The Recovery Model recognizes that Behavioral Health issues involve an individualized complex interaction between social, environmental and physiological components, and the need to incorporate all of these factors within the care system in order to achieve health and wellness.

~~1.90.~~1.94. **Request for Solutions** — Document released in December 2011 by DHCS to assess if contractors have the ~~requisite~~ qualifications and resources ~~suited~~ to provide seamless access to the full continuum of medical care and social supports and services that Enrollees need to maintain good health and a high quality of life in the setting of their choice.

~~1.91.~~

~~1.92.~~1.95. **Rural Health Clinic (RHC)** — An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.

~~1.93.~~1.96. **Service Area** — The county or counties that the Contractor is approved to

operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by CMS and DHCS to operate under the terms of this Contract. See Appendix I for the Service Area for this contract.

~~1.94.~~1.97. **Skilled Nursing Facility (SNF)** — As defined in California Code of Regulations, Title 22 section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing facility".

1.98. **State ~~Fair~~ Hearing** — A "State ~~Fair~~ Hearing" is 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, made by an agency. An "agency" is a government unit or managed care health plan involved in a hearing as a hearing party. Such agencies include all 58 California counties, the Los Angeles Department of Children and Family Services, the California Department of Aging, the CDSS Office of Services to the Blind, all 27 Medi-Cal Field Offices, and several CDHS units, including: Beneficiary Utilization Review Unit, Benefits Branch-Vision, In-Home Operations, Managed Care Operations Branch, Recovery Section, and Office of Medi-Cal Dental Services.

~~1.95.~~1.99. State Plan — The Medicaid State Plan is based on the requirements set forth in Title XIX of the Social Security Act and is a comprehensive written document created by the State of California that describes the nature and scope of its Medicaid (Medi-Cal) program. It serves as a contractual agreement between the State of California and CMS and must be administered in conformity with specific requirements of Title XIX of the Social Security Act and regulations outlined in Chapter IV of the Code of Federal Regulations.

1.100. **Streamlined Enrollment** — A process to permit Contractors operating in non-COHS counties to submit opt-in enrollments to DHCS on behalf of their members enrolled in the matching plan's Medi-Cal line of business.

1.101. **Telehealth** — Consistent with Section 1834(m) of the Social Security Act, the mode of delivering health care services by using 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 a separate location from the health care Provider. Telehealth facilitates the Member's self-management and caregiver support for the Member and includes synchronous interactions and asynchronous store and forward transfers.

~~1.96.~~1.102. **Threshold Languages** —~~-~~Those languges that meet the more stringent of either (1) Medicare's five (5) percent threshold for language translation; or (2) DHCS' prevalent langua~~gue~~ requirements (the DHCS threshold and concentration standard languages), ~~-A~~as specified in annual guidance to Contractors on specific translation requirements for their service areas.

~~1.97.~~1.103. **Total Adjusted Expenditures** — The sum of the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures.

~~1.98.~~1.104. **Total Capitation Rate Revenue** — The sum of the monthly capitation payments for the Demonstration Year (reflecting coverage of Medicare Parts A/B services, Medicare Part D services and Medi-Cal services, pursuant to Appendix A of this C~~c~~ontract) including: 1) the application of risk adjustment methodologies, as described in Section 4.2; and 2) any payment adjustments as a result of the reconciliation described in Sections 4.153~~3~~ and 4.164. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

~~1.99.~~1.105. **Two- Plan County** — A type of Medi-Cal managed care delivery model in which DHCS contracts two plans, offering beneficiaries a choice of health plan a with a "Local Initiative" (LI) and a "commercial plan" (CP). An LI is a non-profit, locally government health plan serving Medi-Cal beneficiaries.

~~1.100.~~1.106. **Urgent Care** — Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

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2. Contractor Responsibilities

Through the Capitated Financial Alignment Model Demonstration (the "Demonstration"), CMS and DHCS will work in partnership to offer Medicare-Medicaid Enrollees the option of enrolling in a Contractor's plan, which consists of a comprehensive network of health and social service providers. The Contractor will deliver and coordinate all components of Medicare and Medi-Cal Covered Services for Enrollees.

2.1. Compliance: The Contractor must, to the satisfaction of CMS and DHCS:

2.1.1. Comply with all provisions set forth in this Contract.

2.1.2. Comply with all applicable provisions of federal and State laws, the CFAM-MOU, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422, Part 423, and Part 438 except to the extent that variances from these requirements are provided in the CFAM-MOU.

2.1.3. Maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 as amended and have no adverse actions with regard to enforcement or quality management. County-Organized Health System (COHS) plans are exempt from Knox-Keene licensure for their Medi-Cal business pursuant to WIC section 14087.95. Despite this exemption from licensure, this Contract obligates all Contractors, including COHS plans, to comply with all provisions of this Contract, including the contractual provisions relating to the Knox-Keene Act, unless otherwise expressly excluded.

2.1.4. The Contractor agrees that it will develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455.

2.1.4.1. The Contractor must report all employees, providers, and Enrollees suspected of Fraud, waste, and/or Abuse that warrant investigation to DHCS – Office of Inspector General, the Medicaid Fraud Control Unit and CMS.

2.1.5. Comply with all current and applicable DPLs issued by DHCS. All current DPLs can be viewed at: http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx

2.1.5.1. All DPLs will be reviewed by CMS prior to issuance.

2.1.6. In the event an APL applies to an MMP, DHCS and CMS will jointly issue a memo to the plans via HPMS for the interim period between an APL issuance and a DPL issuance.

2.1.7. Maintain its contract with DHCS for the provision of Covered Services under the Medi-Cal program.

2.1.8. For Contractors that make or receive payments under the contract of at least $5,000,000, the Contractor must adopt and implement written policies for all employees of the Contractor, and of any contractor or agent of the Contractor, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

2.1.9. Accreditation

2.1.9.1. The Contractor agrees to authorize NCQA- to provide DHCS and CMS with a copy of the most recent accreditation review, including but not limited to status, survey type and level; any recommendation for actions or improvements; any corrective action plans; summaries of findings; and the expiration date of the accreditation.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS, or its designee, with participation by DHCS, will conduct a Readiness Review of each Contractor, which must be completed successfully prior to the Contract Operational Start Date.

2.2.1.2. CMS and DHCS Readiness Review Responsibilities

2.2.1.2.1. CMS and DHCS, or its designees, will conduct a Readiness Review of each Contactor that will include, at a minimum, one on-site review. This review shall be conducted prior to enrollment of beneficiaries into the Contractor's Plan. CMS and DHCS, or its designees, will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.9;

2.2.1.2.2.2. Staffing, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with Section 2.10;

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2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix C;

2.2.1.2.2.4. Care Coordination capabilities, in accordance with Section 2.5.1;

2.2.1.2.2.5. Provider contracts templates, including any Provider Performance Incentives, in accordance with Sections 2.9 and 5.1.7;

2.2.1.2.2.6. Enrollee services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.12;

2.2.1.2.2.7. Comprehensiveness of quality management/quality improvement and utilization management strategies, in accordance with Section 2.11.6 and 2.16;

2.2.1.2.2.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.14 and 2.15;

2.2.1.2.2.9. Fraud and abuse and program integrity, in accordance with Section 2.1.2;

2.2.1.2.2.10. Financial solvency, in accordance with Section 2.18;

2.2.1.2.2.11. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.19, including IT testing and security assurances.

2.2.1.2.3. For Contractors that are COHS plans, the scope of the Readiness Review will extend to the enrollment functions that the Contractor will be conducting as described in Section 2.3.1.

2.2.1.2.4. No individual shall be enrolled into the Contractor's Cal MediConnect Plan unless and until CMS and the DHCS determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.5. CMS and DHCS or its designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.6. CMS or DHCS may, in its discretion, postpone the date the Contractor may start marketing or the Contract Operational Start

Date for any Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy CMS or DHCS that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or DHCS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or DHCS may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3. Contractor Readiness Review Responsibilities

2.2.1.3.1. The Contractor shall demonstrate to CMS and DHCS satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its Demonstration product;

2.2.1.3.2. Provide CMS and DHCS or its designee with the corrected materials requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. The Contractor must employ a qualified individual to serve as the compliance officer of its Capitated Financial Alignment Model. The compliance officer must be primarily dedicated to the Contractor's program, hold a senior management position in the Contractor's organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program. The compliance officer must act as liaison between the Contractor, CMS, and DHCS, and has responsibilities pursuant to this Contract, DPLs and other relevant guidance and authorities that include but, are not limited to, the following:

2.2.2.1.1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the approved Request for Solutions (RFS);

2.2.2.1.3. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities.

2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS and DHCS in timeframes and formats specified by CMS and DHCS;

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2.2.2.1.5. Meet with representatives of CMS or DHCS, or both, on a periodic or as-needed basis and resolve issues that arise within specified timeframes;

2.2.2.1.6. Ensure the availability to CMS and DHCS upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee services, utilization management, Provider Network management, and benefit coordination;

2.2.2.1.7. Coordinate requests and activities among the Contractor, all First Tier, Downstream and Related Entities CMS, and DHCS;

2.2.2.1.8. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or DHCS; and

2.2.2.1.9. Meet with CMS and DHCS at the time and place requested by CMS and the State, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.3. Organizational Structure

2.2.3.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with:

2.2.3.1.1. County Organized Health System, Geographic Managed Care, and Two- Plan County: Title 28 CCR Sections 1300.67.3, 1300.75.1, 1300. 76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code, Section 1375.1.

2.2.4. Delegation Oversight

2.2.4.1. Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

2.2.4.2. Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

2.2.4.3. Contractor's Quality Improvement (QI) department shall maintain documentation of oversight activities.

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2.2.4.4. Contractor's delegation oversight and monitoring activities shall emphasize results. To that end, Contractor shall identify areas requiring improvement and shall monitor the performance of the First Tier, Downstream, and Related Entities to ensure that such improvement occurs.

2.2.4.5. Contractor delegates activities to its First Tier, Downstream, and Related Entities in accordance with terms and conditions, contracts, applicable regulations, and this contract.

2.2.4.6. Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

2.2.4.6.1. Desktop and annual on-site revises;

2.2.4.6.2. Monitoring; and

2.2.4.6.3. Continuous improvement activities.

2.3. Enrollment Activities

2.3.1. General Enrollment

2.3.1.1. Contractor shall accept all eligible beneficiaries as defined in Appendix J – Eligible Populations.

2.3.1.2. Eligible beneficiaries residing within the Contractor Service Area may be enrolled at any time up to ~~six (6) months prior to~~ the end of the Demonstration. Eligible beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, need for health care services or disability.

2.3.1.3. Enrollee coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the eligible beneficiary's name is added to the approved list of Enrollees furnished by CMS and the DHCS Enrollment Broker. The term of enrollment shall continue unless this Contract expires, is terminated, or the Enrollee is disenrolled under the conditions described in Section 2.3.2, Disenrollment.

2.3.1.4. Enrollment will proceed unless restricted by CMS or the S~~s~~tate. Such restrictions will be defined in writing by CMS or the S~~s~~tate and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) calendar days ~~calendar~~ prior to the date of the release.

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2.3.1.5. Intelligent Assignment. Enrollment activities specific to Two-Plan Counties and GMC Counties (Los Angeles, San Diego, San Bernardino, Santa Clara, Riverside):

2.3.1.5.1. On a quarterly basis, Contractor shall provide DHCS with a complete list of Network Providers and National Provider Identifier (NPI) numbers to assist in the assignment of eligible beneficiaries as part of the Passive Enrollment process. The Network Provider list will include all Network Providers for the Provider Network, where applicable.

2.3.1.5.2. Updates to the Network Provider list shall be sent to DHCS on a quarterly basis for the purposes of intelligent assignment, or as changes to the Provider Network are applied.

2.3.1.5.3. As part of the Enrollment process, DHCS will exclude individuals identified as at-risk or potentially at-risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 423.100 and 423.153(f).

2.3.1.5.4. As part of the Passive Enrollment process, DHCS will initially assign an Enrollee to a Cal MediConnect Plan based on a hierarchical logic in accordance with Section 2.3.1.5.1. Subject to 42 C.F.R. §§ 423.100 and 423.153(f), Enrollees shall have the ability to change Cal MediConnect Plans at any time.

2.3.1.5.4.1. DHCS shall utilize the following hierarchical logic to determine Primary Contractor Plan assignment:

2.3.1.5.4.1.1. If a beneficiary is in a Medi-Cal Managed Care Plan that is participating in the Cal MediConnect Program and is not enrolled in a Medicare Advantage product, DHCS will assign the beneficiary to the matching Cal MediConnect plan.

2.3.1.5.4.1.2. If the beneficiary is in a Medicare Advantage Dual Special Needs Plan owned by the parent organization of an MMP, DHCS will assign the beneficiary to the matching MMP.

2.3.1.5.4.1.3. If a beneficiary is in fee-for-service Medi-Cal and Medicare, DHCS will match the beneficiary's highest utilized and paid prescribing and/or rendering provider data [based on the most recent and available twelve (12) months of Medicare and Medi-Cal claim data] to the list of Network Providers supplied by the Contractor, in accordance with Section 2.3.1.5.1.

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2.3.1.5.4.1.4. If only one (1) Cal MediConnect Plan is identified with the beneficiary's provider(s) in its network, DHCS will assign the beneficiary to that Cal MediConnect Plan.

2.3.1.5.4.1.5. If two (2) or more Cal MediConnect Plans are identified or if there is insufficient claim data to match to a Cal MediConnect Plan, the system will select a Cal MediConnect Plan based on an equal distribution ratio. For example, if there are two (2) Cal MediConnect Plans in the county, DHCS will assign based on a 50/50 split. In San Diego, the system will divide beneficiary assignments equally across the four (4) Cal MediConnect Plans.

2.3.1.5.4.1.6. This distribution is dependent on Contractor capacity and subject to be altered per the direction of the Contract Management Team (CMT).

2.3.1.5.5. DHCS will notify CMS and the Contractor of the beneficiary assignments via the enrollment transactions sent to CMS and the 834 Enrollment file.

2.3.1.5.6. DHCS will inform the Contractor of the provider NPIs used in the plan selection process.

2.3.1.5.7. CMS will notify the Contractor of the beneficiary assignments via the Daily Transaction Response Reply (DTRR) file distributed through the CMS Enrollment Broker.

2.3.1.5.8. Contractor is responsible for outreach to the Network Provider for enrollment related activities and for providing data to DHCS.

2.3.1.5.9. Contractor shall maintain systems to accept enrollment transactions from CMS' and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, posted at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf

2.3.1.6. Enrollment activities specific to County Organized Health Systems.

2.3.1.6.1. Contractor shall maintain systems to identify eligible beneficiaries as defined in Appendix J, and transmit enrollment transactions to CMS and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance Document.

2.3.1.7. Subject to CMT approval and Section 2.17.1.1.2, the Contractor may participate in Streamlined Enrollment.

2.3.1.7.1. Eligible Enrollees must be enrolled in the Contractor's Medi-Cal plan product.

2.3.1.8. CMS and DHCS may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

2.3.1.9. The Contractor may, via the CMT, request a capacity limit pursuant to 42 C.F.R. § 422.60. For purposes of this Demonstration, CMS and DHCS will consider financial stability and network adequacy in the determination of a capacity limit.

2.3.2. Disenrollments

2.3.2.1. The Contractor shall have a mechanism for receiving timely information about all disenrollments from the Contractor's plan, including the effective date of disenrollment, from CMS and DHCS systems.

2.3.2.2. Contractor in Two-Plan and GMC Counties shall have processes and procedures in place to refer Enrollees that request disenrollment from the Plan to the DHCS Enrollment Broker.

2.3.2.3. Enrollees with a share of cost that do not meet the share of cost on the first of the month will be deemed eligible and remain enrolled for up to two (2) months at the Contractor's responsibility before being disenrolled per California's State-specific guidance to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (Section 2.3.1.5.9). Please see Appendix J for eligibility requirements for beneficiaries with a share of cost.

2.3.2.4. Subject to 42 C.F.R. §§ 423.38 and 423.100, Enrollees can elect to disenroll from the Cal MediConnect Plan or the Demonstration at any time and enroll in another Cal MediConnect Plan in a Two-Plan County or GMC county, a Medicare Advantage plan, PACE (as otherwise permissible); or elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive Medicaid services in accordance with DHCS's Medi-Cal program and any waiver programs (see Appendix L). Disenrollments received by DHCS or its contractor, or by CMS or its contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

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2.3.2.4.1. The Contractor shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.2.4.2. DHCS and CMS shall terminate an Enrollee's coverage upon any of the occurrences specified in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including but not limited to the following:

2.3.2.4.2.1. The Enrollee's death. This disenrollment is effective the first day of the calendar month following the month of death. Termination may be retroactive to the month in which the Enrollee dies.

2.3.2.4.2.2. When an Enrollee elects to change Demonstration Plans. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.3. When an Enrollee requests and is enrolled in a new Medicare Advantage plan through 1-800-Medicare. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.4. When an Enrollee elects to receive his or her Medicare services through Medicare fee-for-service and a separate Medicare prescription drug plan.

2.3.2.4.2.5. The termination or expiration of this Contract terminates coverage for all Enrollees with the Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the parties.

2.3.2.4.3. The Contractor may not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Contractor, however, may submit a written request, accompanied by supporting documentation to the CMT to disenroll an Enrollee, for cause, for the following reasons:

2.3.2.4.3.1. Enrollee remains out of the Service Area or cannot be located for more than six (6) consecutive months; or

2.3.2.4.4. The Contractor may not threaten, intimidate, pressure, or otherwise interfere with the Enrollee's right to disenroll.

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2.3.2.5. Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to Cal MediConnect Plans on discretionary involuntary disenrollment. This Contract and ~~other~~ the Medicare-Medicaid Plan Enrollment and Disenrollment guidance provide procedural and substantive requirements the Contractor, DHCS, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, DHCS and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements.

2.3.2.5.1. Bases for Discretionary Involuntary Disenrollment:

2.3.2.5.1.1. Disruptive conduct: When the Enrollee engages in conduct or behavior that substantially impairs the Contractor's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.2.5.2. Procedural requirements:

2.3.2.5.2.1. The Contractor's request must be in writing and include all of the supporting documentation outlined under the evidentiary standards in Section 2.3.2.5.3.

2.3.2.5.2.2. The process requires three (3) written notices. The Contractor must include in the request, submitted to DHCS and CMS, evidence that the advance notice and notice of intent have already been sent to the Enrollee. The notices are:

2.3.2.5.2.2.1. Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the disruptive conduct and its impact on the Contractor's ability to provide services, examples of the types of reasonable accommodations the Contractor has already offered, the Grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor must begin the process again. This includes sending another advance notice.

2.3.2.5.2.2.2. Notice of intent to request the State and CMS' permission to disenroll the Enrollee; and

2.3.2.5.2.2.3. Planned action notice advising that CMS and the State have approved the Contractor's request. This planned action notice is not a procedural prerequisite for approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and DHCS.

2.3.2.5.2.3. The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

2.3.2.5.2.4. The submission must include statements from providers describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and

2.3.2.5.2.5. Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.

2.3.2.5.2.6. If the Contractor is requesting the ability to decline future Enrollments for this individual, the Contractor must include this request explicitly in the submission.

2.3.2.5.2.7. Prior to approval, the complete request must be reviewed by DHCS and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.

2.3.2.5.3. Evidentiary standards: At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both DHCS and CMS staff with appropriate clinical or medical expertise:

2.3.2.5.3.1. The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the Contractor's ability to furnish Covered Items and Services to the Enrollee and/or other Enrollees.

2.3.2.5.3.2. The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.2.5.3.2.1. A documented effort to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act including

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those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. DHCS and CMS will determine whether the reasonable accommodations offered are sufficient.

2.3.2.5.3.2.2. A documented provision of information to the individual of his or her right to use the Grievance procedures.

2.3.2.5.3.2.3. The Contractor provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.

2.3.2.5.3.3. The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.2.5.3.4. The Contractor may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct;

2.3.2.5.4. Limitations: The Contractor shall not seek to terminate enrollment because of any of the following:

2.3.2.5.4.1. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating providers explicitly document their belief that there are no reasonable accommodations the Contractor could provide that would address the disruptive conduct.

2.3.2.5.4.2. The Enrollee exercises the option to make treatment decisions with which the Contractor or any health care professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

2.3.2.5.4.3. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services.

2.3.2.5.4.4. The Enrollee's mental capacity is, has, or may become diminished.

2.3.2.5.5. Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.2.5.5.1. The Contractor may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on

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the election form, fraudulent information that materially affects the individual's eligibility to enroll in the Contractor's plan; or if the Enrollee intentionally permits others to use his or her enrollment card to obtain services from the Contractor.

2.3.2.5.5.2. Prior to submission, the Contractor must have and provide to CMS/DHCS credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.

2.3.2.5.5.3. The Contractor must immediately notify the CMT so that the Enrollment Broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

2.3.2.5.6. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the plan's decision and information on the Enrollee's access to Grievance procedures and a fair hearing.

2.4. Covered Services

2.4.1. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the Contractor. Covered Services include the Behavioral Health services that become Medi-Cal managed care benefits, pursuant to Welfare and Institutions Code section 14132.03.

2.4.2. The Contractor must provide the full range of Covered Services. If either Medicare or Medi-Cal provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program.

2.4.3. Care Plan Option (CPO) Services may be provided at the sole discretion of the Contractor and in accordance with the ICP.

2.4.3.1. The Grievance and Appeals process for CPO Services shall be the same process as used for others benefits authorized by the Contractor, as described in Sections 2.14 and 2.15, and shall comply with Welfare & Institutions Code section 14450 and Health & Safety Code sections 1368 and 1368.1.

2.4.3.2. CPO Services may include, but are not limited to:

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~~2.4.3.2.1. Respite care: in home or out-of-home, which shall not supplant authorized IHSS hours;~~

~~2.4.3.2.2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; Contractor will notify counties if additional personal care services are provided.~~

~~2.4.3.2.3.~~2.4.3.2.1. Nutritional assessment, supplements, and home delivered meals;

~~2.4.3.2.4. Home maintenance and minor home or environmental adaptation; and~~

~~2.4.3.2.5.~~2.4.3.2.2. Supplemental protective supervision.

2.4.3.3. Other services and requirements in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

2.4.4. Community Supports

2.4.4.1. Contractor's Responsibility for Administration of Community Supports

2.4.4.1.1. Contractor is authorized and encouraged to provide DHCS pre-approved Community Supports.

2.4.4.1.1.1. The remainder of this section refers only to Community Supports that the Contrctor elects to offer unless otherwise specificed.

2.4.4.1.2. To offer Community Supports in accordance with 42 C.F.R. § 438.3(e)(2), Contractor may select from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan.

2.4.4.1.2.1. Contractor must ensure medically appropriate State Plan services are made available to the Enrollee regardless of whether the Enrollee has been offered a Community Supports, is currently receiving a Community Supports, or has received a Community Supports in the past.

2.4.4.1.2.2. Contractor may not require an Enrollee to utilize a Community Supports. Enrollees always retain their right to receive the California Medicaid State Plan Covered Service on the same terms as would apply if a Community Supports was not an option in accordance with regulatory requirements.

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2.4.4.1.2.3. Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

2.4.4.1.3. With respect to pre-approved Community Supports, Contractor shall adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports providers, and parameters for each Community Supports 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.

2.4.4.1.3.1. Contractor is not permitted to extend a Community Supports to Enrollees 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.

2.4.4.1.3.2. 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 Summary of Benefits and on Contractor's Website, in addition to receiving DHCS' written approval.

2.4.4.1.4. If Contractor elects to offer one or more pre-approved Community Supports, Contractor 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. For requirements regarding the extent to which Community Supports must be provided throughout a county selected by Contractor.

2.4.4.1.5. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must identify Enrollees who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for State Plan Covered Services, and accept requests for Community Supports from Enrollees and on behalf of Enrollees from providers and organizations that serve them, including community-based organizations.

2.4.4.1.6. If Contractor elects to offer one or more pre-approved Community Supports, Contractor shall authorize Community Supports for Enrollees deemed eligible.

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2.4.4.1.7. Electing to offer one or more Community Supports shall not preclude Contractor from offering value-added services.

2.4.4.1.8. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must notify DHCS.

2.4.4.1.9. Contractor shall not require Enrollees to use Community Supports.

2.4.4.2. DHCS Pre-Approved Community Supports

2.4.4.2.1. Contractor can choose to offer Enrollees one or more of the following pre-approved Community Supports, and any later DHCS-approved Community Supports additions, in each county:

2.4.4.2.1.1. Housing transition navigation services;

2.4.4.2.1.2. Housing deposits;

2.4.4.2.1.3. Housing tenancy and sustaining services;

2.4.4.2.1.4. Short-term post-hospitalization housing;

2.4.4.2.1.5. Recuperative care (medical respite);

2.4.4.2.1.6. Respite services;

2.4.4.2.1.7. Day habilitation programs;

2.4.4.2.1.8. Nursing facility transition/diversion to assisted living facilities;

2.4.4.2.1.9. Community transition services/nursing facility transition to a home;

2.4.4.2.1.10. Personal care and homemaker services;

2.4.4.2.1.11. Environmental accessibility adaptations;

2.4.4.2.1.12. Medically tailored meals/medically supportive food;

2.4.4.2.1.13. Sobering centers; and/or

2.4.4.2.1.14. Asthma remediation.

2.4.4.2.2. Contractor shall ensure Community Supports are provided to Enrollees in as timely a manner as possible, and shall develop policies and procedures outlining its approach to managing provider

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shortages or other barriers to timely provision of Community Supports.

2.4.4.2.3. Contractor is permitted to begin offering new pre-approved Community Supports every six (6) months upon notice to DHCS.

2.4.4.2.4. Contractor is permitted to discontinue offering previously elected Community Supports annually with notice to DHCS at least ninety(90) days prior to the discontinuation date.

2.4.4.2.4.1. Contractor shall ensure Community Supports that were authorized for an Enrollee prior to the discontinuation of that specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Enrolleeinto other Medically Necessary Services or programs that meet their needs.

2.4.4.2.5. At least thirty (30) days before discontinuing any elected Community Supports, Contractor must notify Enrollees affected by a decision to discontinue an Community Supports of the following:

2.4.4.2.5.1. The change and timing of discontinuation, and

2.4.4.2.5.2. The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other Medically Necessary Services.

2.4.4.2.6. Contractor is not restricted from providing voluntary Care Plan Option services that are neither state-approved Community Supports nor Covered Services when medically appropriate in accordance with 42 C.F.R. § 438.3(e)(1). Such voluntary services are not subject to the terms of this section and are subject to the limitations of 42 C.F.R. § 438.3(e)(1) and take precedence over the pre-approved list of Community Supports.

2.4.4.3. Community Supports Providers

2.4.4.3.1. Community Supports providers are entities that Contractor has determined can provide the Community Supports to eligible Enrollees in an effective manner consistent with culturally and linguistically appropriate care.

2.4.4.3.2. Contractor must contract with Community Supports providers for the delivery of elected Community Supports.

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2.4.4.3.3. Contractor must have a process for verifying qualifications and experience of Community Supports providers, which must exend to individuals employed by, or delivering services on behalf of, the Community Supports provider. Contractor must ensure that all Community Supports providers with which it contracts meet the capabilities and standards required to be a Community Supports provider.

2.4.4.3.4. Contractor must support Community Supports provider access to systems and processes allowing them to obtain and document Enrollee information including eligibility, Community Supports authorization status, Enrollee authorization for data sharing to the extent required by federal law, and other relevant demographic and administrative information, and to support notification to Contractor, Enrollee's PCP, as applicable, when a referral has been fulfilled.

2.4.4.3.5. To the extent Contractor elects to offer Community Supports, Contractor is encouraged to coordinate its approach with other Medi-Cal Managed Care Plans and/or Cal MediConnect plans offering Community Supports in the same county.

2.4.4.4. Community Supports Provider Capacity

2.4.4.4.1. Contractor must develop a robust Network of Community Supports providers to deliver all elected Community Supports.

~~2.4.4.1.1.~~ If Contractor is unable to offer its elected Community Supports to all eligible Enrollees 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.

2.4.4.4.2.

Contractor shall 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 Enrollees who are authorized for such services on an ongoing basis.

2.4.4.4.3.

2.4.4.5. Identifying Enrollees for Community Supports

2.4.4.5.1. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must utilize a variety of methods to identify Enrollees who may benefit from Community Supports.

2.4.4.5.2. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must develop policies and procedures for Community Supports, and 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:

2.4.4.5.2.1. How Contractor will identify Enrollees eligible for Community Supports;

2.4.4.5.2.2. How Contractor will notify Enrollees; and

2.4.4.5.2.3. How Contractor will accept requests for Community Supports from ~~P~~providers, other community-based entities, and Enrollee or Enrollee's family, legal guardians, authorized representatives, caregivers, and other authorized support persons.

2.4.4.5.3. Contractor must submit any Community Supports notices to DHCS for review and approval prior to implementation.

2.4.4.5.4. Contractor must ensure that Enrollee identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

2.4.4.6. Authorizing Enrollees for Community Supports and Communication of Authorization Status

2.4.4.6.1. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must develop policies and procedures that explain how Contractor will authorize Community Supports for eligible Enrollees in an equitable and non-discriminatory manner. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.

2.4.4.6.2. 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.

2.4.4.6.3. Contractor must validate Enrollee eligibility for Community Supports using a consistent methodology and authorize Community Supports for Enrollees for whom the Community Supports are determined to be a medically appropriate and cost-effective

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alternative to Covered Services and settings under the California Medicaid State Plan.

2.4.4.6.3.1. For Enrollees 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 Enrollees. 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 Enrollee to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services.

2.4.4.6.4. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must develop and maintain policies and procedures to ensure Enrollees do not experience undue delays pending the authorization process for Community Supports.

2.4.4.6.4.1. 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.

2.4.4.6.4.2. Contractor must evaluate and document whether a service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Enrollee. Providing particular Community Supports to a Enrollee in one instance does not automatically mean that providing other Community Supports to the same Enrollee, the same Community Supports to another Enrollee, or the same Community Supports to the same Enrollee in a different instance would be medically appropriate and cost-effective.

2.4.4.6.5. If Contractor elects to offer one or more pre-approved Community Supports, 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.

2.4.4.6.6. When a Enrollee has requested Community Supports, directly or through a ~~P~~provider, community-based organization, or other entity, Contractor must notify the requesting entity and Enrollee of Contractor's decision regarding Community Supports authorization.

2.4.4.6.7. Enrollee 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.

2.4.4.6.8. For Enrollees 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.

2.4.4.7. Referring Enrollees to Community Supports Providers for Community Supports

2.4.4.7.1. If Contractor elects to offer one or more pre-approved Community Supports, 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.

2.4.4.7.1.1. Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

2.4.4.7.2. If the Enrollee preferences toward a particular Community Supports provider are known, Contractor must follow those preferences, to the extent practicable.

2.4.4.7.3. Contractor must track referrals to Community Supports providers to verify if the authorized service has been delivered to the Enrollee.

2.4.4.7.4. Contractor must not require Enrollee authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by federal law.

2.4.4.7.5. Contractor must develop and maintain policies and procedures for its network of Community Supports providers to:

2.4.4.7.5.1. Ensure the Enrollee agrees to receive Community Supports;

2.4.4.7.5.2. Where required by law, ensure that Enrollees authorize information sharing with Contractor and all others involved in the

Enrollee's care as needed, to support the Enrollee and maximize the benefits of Community Supports.

2.4.4.7.5.3. Provide Contractor with Enrollee-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

2.4.4.7.5.4. Obtain Enrollee authorization to communicate electronically with the Enrollee, Enrollee's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, if Contractor intends to do so.

2.4.4.8. Data System Requirements and Data Sharing to support Community Supports

2.4.4.8.1. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

2.4.4.8.2. Contractor must support Community Supports provider access to systems and processes allowing them to track and manage referrals for Community Supports and Enrollee information.

2.4.4.8.3. 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:

2.4.4.8.3.1. Demographic and administrative information confirming the referred Enrollee's eligibility and authorization for the requested service;

2.4.4.8.3.2. Appropriate administrative, clinical, and social service information that Community Supports providers might need to effectively provide the requested service; and

2.4.4.8.3.3. Billing information necessary to support the Community Supports providers' ability to submit claims or invoices to Contractor.

2.4.4.8.4. 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.

2.4.4.9. Contractor's Oversight of Community Supports Providers

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2.4.4.9.1. Contractor must comply with all State and federal reporting requirements.

2.4.4.9.2. Contractor must perform oversight of Community Support providers, holding them accountable to all Community Supports requirements contained in this Contract.

2.4.4.9.3. Contractor must use all applicable guidance to develop its subcontracts with Community Support providers and must incorporate all of its Community Supports provider requirements. Contractor must submit its subcontracts with Community Supports providers to DHCS for review and approval.

2.4.4.9.4. To streamline Community Supports implementation, Contractor must ensure the following, if electing to offer one or more pre-approved Community Supports:

2.4.4.9.4.1. Contractor must hold Community Supports providers responsible for the same reporting requirements as are required of Contractor by DHCS.

2.4.4.9.4.2. Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.

2.4.4.9.4.3. Contractor may collaborate with other Medi-Cal Managed Care Plans and/or Cal MediConnect Plans within the same county on reporting requirements and oversight.

2.4.4.9.5. 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.

2.4.4.9.6. 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.

2.4.4.10. Delegation of Community Supports Administration to Subcontractors

2.4.4.10.1. Contractor may enter into subcontracts with other entities to administer Community Supports in accordance with the following:

2.4.4.10.1.1. Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services;

2.4.4.10.1.2. Contractor is responsible for developing and maintaining DHCS-approved policies and procedures to ensure Community Supports providers meet required responsibilities and functions;

2.4.4.10.1.3. Contractor must evaluate the prospective subcontractors ability to perform services;

2.4.4.10.1.4. Contractor must ensure the subcontractor's Community Supports provider capacity is sufficient to serve all referred Enrollees;

2.4.4.10.1.5. Contractor must report to DHCS the names of all subcontractors by type and service(s) provided, and identify the county or counties in which Enrollees are served; and

2.4.4.10.1.6. Contractor must make all subcontracts available to DHCS upon request. Such subcontracts must contain minimum required information specified by DHCS, including method and amount of compensation.

2.4.4.10.2. Contractor must ensure that the subcontract mirrors the requirements set forth in this Contract.

2.4.4.10.3. 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 Enrollees.

2.4.4.11. Payment of Community Support Providers

2.4.4.11.1. Contractor must pay contracted Community Supports providers for the provision of authorized Community Supports to Enrollees in accordance with established subcontractos between Contractor and each Community Supports provider.

2.4.4.11.2. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Enrollee, such as recuperative care for an individual who is homeless and being discharged from the hospital. For such circumstances,

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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.

2.4.4.11.3. Contractor must ensure Community Supports providers submit a claim for rendered Community Supports, to the greatest extent possible.

2.4.4.11.3.1. 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.

2.4.4.11.3.2. Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

2.4.4.12. DHCS Oversight of Community Supports

2.4.4.12.1. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must provide details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered in and its network of Community Supports providers.

2.4.4.12.2. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

2.4.4.12.2.1. Encounter Data

2.4.4.12.2.2. Quarterly Implementation Monitoring Report

2.4.4.12.2.2.1. 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.

2.4.4.12.2.2.2. Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under subcontractors.

2.4.4.12.2.2.3. 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.

2.4.4.12.2.2.4. 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.

2.4.4.12.2.3. Supplemental reporting on a schedule and in a form to be defined by DHCS.

2.4.4.12.3. 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:

2.4.4.12.3.1. Data to evaluate the utilization and effectiveness of a Community Support~~s~~.

2.4.4.12.3.2. 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.

2.4.4.12.3.3. Data necessary to monitor Enrollee appeals and grievances associated with Community Supports.

2.4.4.12.4. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions.

2.4.4.13. Community Supports Quality and Performance Incentive Program

2.4.4.13.1. If Contractor elects to offer one or more pre-approved Community Supports, Contractor must meet all quality management and Quality Improvement requirements and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

2.4.4.13.2. 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.

2.4.5. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

2.4.5.1. Furnished by the Contractor by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2);

2.4.5.2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person;

2.4.5.3. Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

2.4.5.4. Furnished by an individual or entity that is included on the preclusion list, as defined in 42 C.F.R. § 422.222.

2.4.6. The Contractor may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.5. Care Delivery Model

2.5.1. Contractor shall abide by the care delivery model described within this Contract and is not required to submit a model of care to CMS or DHCS unless otherwise requested.

2.5.2. Care Coordination. The Contractor shall offer Care Coordination and case management services to all Enrollees, as described in Welfare and Institutions Code sections 14182.17(d)(4) and 14186(b).

2.5.2.1. Contractor will coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and LTSS.

2.5.2.2. Contractor will focus on providing services in the least restrictive setting.

2.5.2.3. Care Coordination will be led by the Care Coordinator with participation by members of the ICT.

2.5.2.4. Contractor shall ensure effective linkages of clinical and management systems among Network Providers. Such linkages shall be established in plan policies and procedures.

2.5.2.4.1. Such linkages shall include communication protocols among First Tier, Downstream, and Related Entities.

2.5.2.5. Contractor's policies and procedures shall clarify all communications and reporting protocols related to coordination of services including but not limited to how Contractor shall oversee all such coordination activities.

2.5.2.6. Contractor will ensure that Care Coordination services:

2.5.2.6.1. Reflect a person-centered, outcome-based approach, consistent with the, CFAM-MOU, and DHCS' RFS;

2.5.2.6.2. Follow Enrollee's direction about the level of involvement of his or her caregivers or medical providers;

2.5.2.6.3. Span medical and LTSS systems, including coordination with IHSS, with a focus on transitions;

2.5.2.6.4. Reflect coordination with county agencies and direct contractors, if applicable, for Behavioral Health services;

2.5.2.6.5. Reflect coordination with county agencies, if applicable, for IHSS services;

2.5.2.6.6. Reflect coordination with Medi-Cal Dental and any MMP supplemental dental benefits, as applicable, for dental services;

2.5.2.6.7. Include development of Individual Care Plans (ICP) with Enrollees, as described in Section 2.8.3;

2.5.2.6.8. Are performed by nurses, social workers, Primary Care Providers, if appropriate, other medical, Behavioral Health, or LTSS professionals, and health plan Care Coordinators, as applicable; and

2.5.2.6.9. Reflect access to appropriate community resources, as defined in Welfare and Institution Code sections 14132.275(f)(7) and

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14182.17(d) (4)(G) and (6)(B) and monitoring of skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

2.5.2.7. Contractor will have a process for assigning a Care Coordinator to each Enrollee. Assignment will be made to a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs.

2.5.2.7.1. Contractor shall ensure an adequate ratio of Care Coordinators to Enrollees to provide Care Coordination as required through this Contract. The CMT shall monitor the ratio of Care Coordinators to Enrollees on a regular basis.

2.5.2.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health Services delivered by a county Behavioral Health agency and IHSS services, when applicable. ICTs must be comprised of professionals appropriate for the needs, preferences, and abilities of the Enrollee.

2.5.2.8.1. Every Enrollee will have access to an ICT.

2.5.2.8.2. Enrollees may request the exclusion of any ICT member.

2.5.2.8.3. Contractor must include information about the ICT and ICP in their new member welcome packets.

2.5.2.8.4. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.2.8.5.1 to stabilize medical conditions, increase compliance with Care Plans, maintain functional status, and meet individual Enrollees Care Plan goals. ICT functions will include, at a minimum:

2.5.2.8.4.1. Develop and implement an ICP with Enrollee and/or caregiver participation as further described in Sections 2.5.2.9 and 2.8.3;

2.5.2.8.4.2. Conduct ICT meetings periodically, including at the Enrollee's discretion;

2.5.2.8.4.3. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;

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2.5.2.8.4.4. Maintain a call line or other mechanism for Enrollee inquiries and input , and a process for referring to other agencies, such as LTSS, IHSS, or Behavioral Health agencies, as appropriate;

2.5.2.8.4.5. Conduct conference calls among the Contractor, providers, and Enrollees;

2.5.2.8.4.6. Maintain a mechanism for monitoring Enrollee complaints and Grievances; and

2.5.2.8.4.7. Use secure email, fax, web portals or written correspondence to communicate. The ICT must take the Enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the Enrollee.

2.5.2.8.5. Composition of ICT. ICT must be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.5.2.8.5.1. The ICT will be led by professionally knowledgeable personnel to address the Enrollee's medical, behavioral and LTSS care. If the ICT is led by a PCP, the PCP must be credentialed. ICT will include the Enrollee and/or authorized representative, family and/or caregiver if approved by the Enrollee, PCP (this may be a specialist, if a specialist is serving as the PCP), Care Coordinator, and may include the following persons, as needed and if applicable:

2.5.2.8.5.1.1. Hospital discharge planner;

2.5.2.8.5.1.2. Nursing facility representative;

2.5.2.8.5.1.3. Social Worker, including the IHSS social worker if IHSS services are provided;

2.5.2.8.5.1.4. Specialized providers, such as pharmacists and physical therapists;

2.5.2.8.5.1.5. If receiving IHSS, the IHSS provider, if authorized by Enrollee;

2.5.2.8.5.1.6. If enrolled in CBAS, the CBAS provider, if authorized by Enrollee;

2.5.2.8.5.1.7. MSSP care manager;

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2.5.2.8.5.1.8. Behavioral Health specialist, which may include, but is not limited to, a specialty mental health provider or a substance use disorder counselor; and

2.5.2.8.5.1.9. Other professionals, as appropriate, and as delineated in applicable and current DPLs

2.5.2.8.6. Communication with ICT. Contractor will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Enrollees. Contractor will have a documented process for coordinating the exchange of information amongst all ICT members, including when a change in ICT membership occurs.

2.5.2.8.7. Contractor will have procedures for notifying the ICT of emergency department use, hospital admission (psychiatric or acute) or SNF and coordinating a discharge plan.

2.5.2.8.8. Competencies of ICT. Contractor will provide training for ICT members, and potential ICT members, initially and on an annual basis. Required training topics include:

2.5.2.8.8.1. Person-centered planning processes;

2.5.2.8.8.2. Cultural competence;

2.5.2.8.8.3. Accessibility and accommodations;

2.5.2.8.8.4. Independent living and recovery and wellness principles;~~and~~

2.5.2.8.8.5. Information about LTSS programs, eligibility for these services, and program limitations;~~.~~

2.5.2.8.8.6. Coordination with counties on IHSS~~.~~; and

~~2.5.2.8.8.6.~~2.5.2.8.8.7. Coordination with MSSP sites.

2.5.2.8.9. Nothing in this contract shall be construed as requiring the Enrollee to participate on the ICT. The Contractor shall allow the Enrollee to opt-out of the ICT at any time and the ICT shall be able to continue its operations. Enrollees may not be disenrolled for lack of participation on the ICT. Criteria for disenrollment are discussed in Section 2.3.2.

2.5.2.8.10. If an Enrollee refuses an ICT, at a minimum the Care Coordinator must provide his or her contact information to the Enrollee

and re-visit the refusal at the time of reassessment, or if the Enrollee's PCP changes.

2.5.2.8.11. The administration of the ICT will also follow all applicable current DPLs.

2.5.2.9. Individual Care Plan (ICP). Contractor will develop an ICP for each Enrollee. Contractor will regularly engage Enrollees and/or their representatives in the design, reassessment and updates of the ICPs.

2.5.2.9.1. Enrollees or their authorized representative must have the opportunity to review and sign the ICP and any of its amendments. Contractor must provide Enrollees with copies of the ICP and any of its amendments. The ICP must be made available in ~~alternative format~~Alternative Formats and in an Enrollee's preferred written or spoken language.

2.5.2.10. If an Enrollee refuses to be involved in ICP development, the Contractor must seek to re-visit the refusal at least at the time of reassessment, or if the Enrollee's PCP changes.

~~2.5.2.10.~~2.5.2.11. If an Enrollee is unable to be reached or unwilling to participate then an ICP should be developed based on claims data or other information that the Contractor has available.

~~2.5.2.11.~~2.5.2.12. ICPs will include:

~~2.5.2.11.1.~~2.5.2.12.1. The name and contact information for the Enrollees current, assigned Care Coordinator. Enrollee service numbers may be used only if the number will transfer the Enrollee to her/his assigned Care Coordinator;

~~2.5.2.11.2.~~2.5.2.12.2. The name and contact information for the Enrollee's PCP and any specialists;

~~2.5.2.11.3.~~2.5.2.12.3. A complete, current list of the Enrollee's medications;

~~2.5.2.11.4.~~2.5.2.12.4. Enrollee goals, preferences, choices and abilities;

~~2.5.2.11.5.~~2.5.2.12.5. Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS needs as determined through the HRA, Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, and input from members of the ICT, as appropriate;

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~~2.5.2.11.6.~~2.5.2.12.6. Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies, when appropriate;

~~2.5.2.11.7.~~2.5.2.12.7. Timeframes for reassessment and updating of Care Plan, to be done at least annually or if a significant change in condition occurs;

~~2.5.2.11.8.~~2.5.2.12.8. If the Enrollee is receiving Behavioral Health services, the ICP will also include:

~~2.5.2.11.8.1.~~2.5.2.12.8.1. The name and contact information of the primary county or county-contracted Behavioral Health provider;

~~2.5.2.11.8.2.~~2.5.2.12.8.2. Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and

~~2.5.2.11.8.3.~~2.5.2.12.8.3. Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, and evidence of creation or adjustment of care goals.

~~2.5.2.11.9.~~2.5.2.12.9. If the Enrollee is receiving IHSS, the ICP should also include:

~~2.5.2.11.9.1.~~2.5.2.12.9.1. The name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours; and

2.5.2.12.9.2.The name and contact information for the IHSS worker.

~~2.5.2.11.10.~~2.5.2.12.10. If the Enrollee is enrolled in the MSSP waiver, the ICP should also include: the name and contact information for theMSSP care manager

~~2.5.2.11.11.~~2.5.2.12.11. Additional components discussed in current and applicable DPLs consistent with Section 2.1.5.

~~2.5.2.12.~~2.5.2.13. The Contractor will transfer, to another MMP, or its designated Contractor for Enrollees, information necessary to support continuity of care when an Enrollee transfers to another MMP. This information includes, but is not limited to, assessment, ICP, and other pertinent information.

~~2.5.2.12.1.~~2.5.2.13.1. The information shall be provided no later than thirty (30) calendar days from receipt of the notice of disenrollment to the Contractor and in theformat specified by DHCS and CMS.

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~~2.5.2.12.2.~~2.5.2.13.2. This data sharing package and process will be subject to CMT approval following a joint planning process in the first half of 2018 with CMS, DHCS, and the Contractor.

~~2.5.2.12.2.1.~~2.5.2.13.2.1. Detail regarding data transfer methods, the content of the transfer package, look back periods, eligible beneficiaries, and other transfer specifics will be determined via this planning process.

~~2.5.2.13.~~2.5.2.14. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services.

~~2.5.2.13.1.~~2.5.2.14.1. Enrollees may choose to refuse any treatment, including case management.

~~2.5.2.13.2.~~2.5.2.14.2. Basic case management services include:

~~2.5.2.13.2.1.~~2.5.2.14.2.1. A review of clinical information from the provider;

~~2.5.2.13.2.2.~~2.5.2.14.2.2. Completion of the HRA. (see Section 2.8);

~~2.5.2.13.2.3.~~2.5.2.14.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3);

~~2.5.2.13.2.4.~~2.5.2.14.2.4. Identification and referral to appropriate providers and facilities, such as medical, rehabilitation, support services, LTSS, Behavioral Health, Community Supports, Care Plan Option Services, and for covered and non-covered services;

~~2.5.2.13.2.5.~~2.5.2.14.2.5. Direct communication with Enrollee, Enrollee providers, and family;

~~2.5.2.13.2.6.~~2.5.2.14.2.6. Enrollee and family education, including health lifestyle changes when warranted (see Section 2.9.11.8); and

~~2.5.2.13.2.7.~~2.5.2.14.2.7. Coordination of services outside of the Cal MediConnect Plan, such as referral to appropriate community social services, specialty mental health, Drug Medi-Cal services, IHSS service agencies or Medi-Cal Dental.

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~~2.5.2.14.~~2.5.2.15. Complex Case Management. Contractor will develop methods to identify Enrollees who may benefit from complex case management services, using the risk stratification and HRA results (see S~~s~~ections 2.8.1 and 2.8.2) as well as utilization and clinical data and any other available information across medical, LTSS, and Behavioral Health domains, as well as self and provider referrals.

~~2.5.2.14.1.~~2.5.2.15.1. Complex case management services will include:

~~2.5.2.14.1.1.~~2.5.2.15.1.1. Basic case management services (see Section 2.5.2.14 et. seq.)

~~2.5.2.14.1.2.~~2.5.2.15.1.2. Management of acute or chronic illness

~~2.5.2.14.1.3.~~2.5.2.15.1.3. Intense coordination of resources to ensure Enrollee maintains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline, and avoids institutionalization when appropriate and possible.

~~2.5.2.15.~~2.5.2.16. Coordination of Care Management. Contractor shall coordinate with external organization(s) for provision of Covered Services (described in Appendix A) as appropriate for the Enrollee (see Sections 2.6 and 2.7).

~~2.5.2.15.1.~~2.5.2.16.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollee to MSSP organization for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

~~2.5.2.15.2.~~2.5.2.16.2. Contractor shall develop and implement processes for coordination of care for nursing facility residents, including care transition plans and programs to move Enrollees back into the community to the extent possible, in accordance with WIC section 14182.17(d)(4)(H) and in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

~~2.4.3.3.~~2.5.2.17. Coordination of Care Management with external organization for provision of IHSS as appropriate for the Enrollee.

~~2.4.3.3.1.~~2.5.2.17.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollees to county IHSS agency for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

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2.5.2.18. Care Plan Option Services. A CPO Service is optional under the Enrollee's ICP. See Section 2.4.3.

~~2.4.3.4.~~2.5.2.19. Community Supports Services. Community Supports are optional under the Enrollee's ICP. See ~~Subs~~section 2.4.3.

~~2.4.3.5.~~2.5.2.20. Annual Evaluation of Care Management Program. Contractor will conduct annual review, analysis, and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services.

~~2.4.3.5.1.~~2.5.2.20.1. Contractor will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings.

~~2.4.3.6.~~2.5.2.21. Discharge Planning and Care Coordination. Contractor shall ensure provision of discharge planning when Enrollee is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee and/or caregiver. Minimum criteria for discharge planning checklist must include:

~~2.4.3.6.1.~~2.5.2.21.1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received. Documentation of pre-discharge factors, including an understanding of the medical condition or functional status by Enrollee or a representative of the Enrollee as applicable, physical and mental health status, financial resources, and social supports.

~~2.4.3.6.2.~~2.5.2.21.2. Per current and applicable DPLs regarding discharge planning, services needed after discharge, type of placement preferred by the Enrollee/representative of the Enrollee and hospital/institution, type of placement agreed to by the Enrollee/representative of Enrollee, specific agency/home recommended by the hospital, specific agency/home agreed to by the Enrollee/representative of the Enrollee, and pre-discharge counseling recommended.

~~2.4.3.6.3.~~2.5.2.21.3. Post-transition discharge policies and procedures will cover criteria to include, but not limited to, access to necessary medical care and follow up, medications, durable medical

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equipment and supplies, transportation, and integration of community based LTSS programs, as well as coordination with IHSS services authorized by the counties.

~~2.4.3.6.4.~~2.5.2.21.4. Coordination, as appropriate, with: 1) county agencies for IHSS and Behavioral Health services (through social worker and providers, as needed); 2) MSSP providers; 3) CBAS centers; 4) community organizations such as Area Agencies on Aging and DHCS Care Transition projects; 5) LTSS providers, including nursing facilities; 6) specialized providers (including, but not limited to specialists, pharmacists, physical/occupational therapists; 7) Medi-Cal Dental and, 8) others as deemed appropriate. For IHSS, the Contractor's coordination process must be developed jointly with county social service agencies and consider State requirements for counties regarding discharge planning.

~~2.4.3.6.5.~~2.5.2.21.5. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Contractor's Care Coordination process for Enrollees who are being discharged from the hospital or at risk of immediate placement in a SNF.

~~2.4.3.6.6.~~2.5.2.21.6. Summary of the nature and outcome of Enrollee involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

~~2.4.3.6.7.~~2.5.2.21.7. For Enrollees receiving Behavior Health services, Contractor will have procedures developed jointly with the MHP for:

~~2.4.3.6.7.1.~~2.5.2.21.7.1. Notification of the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan, if applicable.

~~2.4.3.6.7.2.~~2.5.2.21.7.2. Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address an Enrollee's medical problems based on changes in the Enrollee's mental health or medical condition.

~~2.4.3.7.~~2.5.2.22. In addition to the oversight of plan complaints, Grievances, and Cal MediConnect Ombuds Program activity via the CMT, the Contractor shall include ombudsman reports in quarterly updates to local advisory convenings and shall participate in all statewide stakeholder and oversight convenings as delineated in DPLs.

2.6. Long-Term Services and Supports (LTSS).

2.6.1. Contractor will ensure access to, provision of, and payment for~~: 1)~~ CBAS for Enrollees who meet eligibility criteria for CBAS as defined in Section 2.6.1.1.1.~~, and 2), MSSP for Enrollees who meet the eligibility criteria for MSSP pursuant to Welfare and Institutions Code section 9560.~~

2.6.1.1. Community Based Adult Services (CBAS): The Contractor shall contract for CBAS, which is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Enrollees.

2.6.1.1.1. The Contractor shall make available the CBAS benefit to Enrollees who are age twenty-one (21) or older and derive their Medi-Cal eligibility from the State Plan, are Medicare beneficiaries, are either aged, blind, or disabled and who qualify based on the following criteria.

2.6.1.1.1.1. Meet medical necessity criteria as established by the State and meet "Nursing Facility Level of Care A" (NF-A) criteria, as set forth in the DHCS Code of Regulations, or above NF-A Level of Care; or

2.6.1.1.1.2. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, stages 5, 6, or 7 of the Alzheimer's Type; or

2.6.1.1.1.3. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, and needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;

2.6.1.1.1.4. Have a Chronic Mental Disorder or acquired, organic, or traumatic brain injury. In addition to the presence of a Chronic Mental Disorder or acquired, organic, or traumatic brain injury, the Enrollee shall need assistance or supervision with either:

2.6.1.1.1.4.1. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

2.6.1.1.1.4.2. One (1) need from the above list and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

2.6.2. Multi-purpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver

that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

2.6.2.1. Contractor shall inform its Enrollees about the MSSP and establish a mechanism to refer Enrollees who are enrolled in Cal MediConnect and are potentially eligible for the MSSP to MSSP providers for eligibility determination.

2.6.2.2. Care Coordination – Contractor shall coordinate and work collaboratively with MSSP providers on Care Coordination activities surrounding the MSSP Waiver Participant including, but not limited to: coordination of benefits between Contractor and MSSP provider to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

2.6.2.3. For Enrollees that may qualify for MSSP, but are on the waiting list, the Contractor may provide alternate services as identified through the development of the ICP as described in Sections 2.5.2.12.7 and 2.8.3.

2.6.2.4. Any MOU that Contractor enters into with MSSP Provider(s) shall be submitted to DHCS for prior approval at least sixty (60) calendar days prior to the effective date of the MOU. DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval within five (5) Working Days of receipt.

2.6.2.4.1. These MOUs shall not become effective until written approval is provided by DHCS and the California Department of Aging (CDA) or by operation of law where DHCS has acknowledged receipt of the proposed MOU, and has neither approved nor rejected the proposed MOU within 60 calendar days of receipt.

2.6.2.4.2. Any new or updated MOU that makes a material change to the MOU must be re-submitted to DHCS. Previous MOU approval shall be valid only until such time as the new or amended MOU is approved by DHCS and CDA.

2.6.2.4.3. Contractor's MOUs with MSSP sites shall provisions for data sharing while following HIPAA regulations for health care operations. At a minimum, MOU data sharing requirements shall include:

2.6.2.4.3.1. MSSP sites sharing initial health and psychosocial assessments;

2.6.2.4.3.2. MSSP sites sharing initial level of care determinations;

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2.6.2.4.3.3. MSSP sites sharing initial care plan;

2.6.2.4.3.4. MSSP sites sharing any re-assessments;

2.6.2.4.3.5. MSSP sites notifying Contractor of Member terminating from MSSP;

2.6.2.4.3.6. Contractor sharing current durable medical equipment authorizations;

2.6.2.4.3.7. Contractor sharing hospitalization information;

2.6.2.4.3.8. Contractor sharing medication list; and

2.6.2.4.3.9. Contractor sharing health risk assessment.

2.6.3. The Contractor will ensure referral to IHSS for Enrollees who meet the eligibility criteria for IHSS pursuant to Welfare and Institutions Code section 12305.6.

2.6.3.1. In-Home Supportive Services (IHSS): A program that serves aged, blind, or disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help pursuant to the California Welfare and Institutions Code (commencing with section 12300) of Chapter 3, and sections 14132.95, 14132.952, and 14132.956.).

2.6.3.1.1. Contractor will coordinate with county agencies to facilitate IHSS participation on the ICT. Contractor will ensure Network Providers coordination with IHSS.

2.6.3.1.2. Contractor will coordinate with county agencies to develop and implement detailed processes for coordination and integration of IHSS which shall include, but not be limited to:

2.6.3.1.2.1. Provision of intake activities and redeterminations by IHSS social workers and allocation of IHSS hours according to WIC section 12301.1 and how that information is coordinated and shared with the ICT.

2.6.3.1.2.2. Framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT.

2.6.3.1.3. DHCS and CDSS will continue to provide the Contractor with IHSS assessment data.

2.6.4. Nursing Facilities

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2.6.4.1. Contractor shall contract with SNFs, as defined in California Code of Regulations Title 22 section 51121(a), in its Service Area that are licensed by California Department of Public Health (CDPH) and certified by DHCS for participation as a SNF in the Medi-Cal Program and additional Contractor credentialing standards, if any. See Section 2.10.2.3.

2.6.4.2. If SNFs beds are not available in the Contractor's Service Area, Contractor shall contract with qualified SNFs in areas outside of the Contractor's Service Area, in correspondence to the Contractor's projected need for SNF beds of its Enrollees.

2.7. Coordinated Primary Care and Behavioral Health.

2.7.1. Contractor shall provide Enrollee access to Behavioral Health services covered by Medicare and Medi-Cal with a focus on the Recovery Model (See Covered Services in Appendix A). Coordination of Behavioral Health services financed and administered by county agencies shall include at a minimum the following:

2.7.1.1. Contractor will develop and implement a plan to ensure seamless access, coordination and delivery of Covered Services that are Medically Necessary to Enrollees who meet the medical necessity criteria.

2.7.1.1.1. To determine responsibility for covering Medi-Cal Specialty Mental Health Services, the Contractor and county will follow the medical necessity criteria for specialty mental health 1915(b) waiver services described in the California Code of Regulations Title 9 sections 1820.205, 1830.205, and 1830.210. The outpatient criteria can be summarized as the following three criteria: 1) diagnosis – one or more of the specified diagnoses; 2) impairment – significant impairment or probability of deterioration of an important area of life functioning; or; 3) intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical health care based treatment.

2.7.1.1.2. To determine medical necessity for Drug Medi-Cal Benefits, Contractor and counties will follow California Code of Regulations Title 22 sections 51303 and 54301. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in California Code of Regulations Title 22 section 51159.

2.7.1.1.3. To determine medical necessity for the authorization of Covered Services that become Medi-Cal managed care Behavioral Health Services on January 1, 2014, pursuant to Welfare and Institutions Code section 14132.03, the Contractor shall use medical necessity

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criteria set forth current and applicable DPL(s) as described in Section 2.1.5.

2.7.1.2. Contractor will have a Memorandum of Understanding (MOU) with county agencies that finance and administer Behavioral Health services. The MOU must be approved by CMS and DHCS. It will include:

2.7.1.2.1. Service Coordination: Contractor will include comprehensive screening for Behavioral Health as part of the HRA (see Section 2.8.2) and ICP (see Section 2.8.3). The local MOU will describe:

2.7.1.2.1.1. Delineation of clinical responsibilities and provider contracting responsibilities;

2.7.1.2.1.2. Point of contact within the Cal MediConnect Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination;

2.7.1.2.1.3. A process for resolving disagreements related to clinical decision making, administrative, and policy issues;

2.7.1.2.1.4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified; and

2.7.1.2.1.5. Processes for clinical consultation and coordination of ICPs.

2.7.1.2.2. Administrative coordination: Contractor will clearly delineate administrative responsibilities and provider contracting responsibilities, including:

2.7.1.2.2.1. Point of contacts and communication processes to address administrative coordination;

2.7.1.2.2.2. Process for annual review and evaluation of administrative management programs; and

2.7.1.2.2.3. Process for demonstrating how administrative problem identification and resolution occurs.

2.7.1.2.3. Information exchange: Contractor will develop data sharing mechanisms with the county Behavioral Health agencies, to the greatest extent practicable under State and federal Privacy laws, to share accurate and timely information to inform care delivery. It will describe:

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2.7.1.2.3.1. Information flow between Contractor and county agencies; and

2.7.1.2.3.2. Processes for exchange of health information.

2.7.1.2.4. Performance measures: Contractor is required to report on measures related to Behavioral Health services for which they have direct contracts with providers including Medicare Behavioral Health benefits.

2.7.1.2.4.1. Contractor is required to show evidence of data sharing agreement with county agencies that provide Medi-Cal Behavioral Health services. The data sharing agreements shall provide for the exchange of data in compliance with all applicable State and federal laws.

2.7.1.2.4.2. Shared financial accountability is discussed in Section 4.9.

2.8. Health Risk Assessments, ICP, and Care Coordination

2.8.1. Risk Stratification. Contractor will use an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs. The health risk stratification shall be conducted in accordance applicable DPL(s) as indicated in Section 2.1.5.

2.8.1.1. Contractor shall use the following data sources to identify an Enrollees' risk level.

2.8.1.1.1. Medicare utilization data, including Medicare Parts A, B, and D.

2.8.1.1.2. Medi-Cal utilization data, including IHSS, MSSP, SNF, and Behavioral Health pharmacy data.

2.8.1.1.3. Results of previously administered assessments.

2.8.1.1.4. Other population- and individual-based tools.

2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and State laws WIC section 14182.17(d)(2), and in accordance with applicable DPL(s) as indicated in Section 2.1.5. Contractor will complete HRAs for all Enrollees.

2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

2.8.2.2. For all Enrollees, the assessment process will, at a minimum, identify:

2.8.2.2.1. Referrals to appropriate LTSS and home- and community-based services;

2.8.2.2.2. Caregivers, Enrollees, and authorized representatives participation;

2.8.2.2.3. Facilitation of timely access to primary care, specialty care, DME, medications, and other health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access;Facilitation of communication among the Enrollee's providers, including Behavioral Health providers as appropriate;

2.8.2.2.4. Identification of the need for providing other activities or services needed to assist Enrollees in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and

2.8.2.2.4.1. Support for Enrollees who need more complex case management, as described in Sections 2.5.2.14 and 2.5.2.15.

2.8.2.2.4.2. Other elements in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5

2.8.2.5. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

2.8.2.6. Reassessments will be conducted at least annually, within twelve (12) months of last assessment, or as often as the health and/or functional status of the Enrollee requires.

2.8.2.6.1. When determining the mode for completing reassessment, the Contractor will consider the reason the assessment needs to be

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updated, the Enrollee's needs and health or functional status, and the preference of the Enrollee.

2.8.2.7. Contractor will regularly use electronic health records and claims data to inform reassessments and to identify Enrollees at high risk, with newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or Behavioral Health referral.

2.8.3. Individualized Care Plan (ICP). A comprehensive, person-centered ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.2.12.7.

2.8.3.1. The Contractor must complete the ICP within ninety (90) calendar days of enrollment.

~~2.4.3.8.~~2.8.3.2. The Contractor will provide the ICP to the Enrollee no less than annually.

~~2.4.4.~~2.8.4. Continuity of Care. Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers as described below and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

~~2.4.4.1.~~2.8.4.1. Contractor must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

~~2.4.4.1.1.~~2.8.4.1.1. A period up to twelve (12) months for Medicare services if all of the following criteria are met under WIC section 14132.275(l)(2)(A):

~~2.4.4.1.1.1.~~2.8.4.1.1.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network PCP or specialist at least once within the previous twelve (12) months from the date of enrollment The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medicare data provided by DHCS or by documentation by the provider or Enrollee;

~~2.4.4.1.1.2.~~2.8.4.1.1.2. Provider is willing to accept payment from the Contractor based on the current Medicare fee schedule; and

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~~2.4.4.1.1.3.~~2.8.4.1.1.3. Contractor would not otherwise exclude the provider from its Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

~~2.4.4.1.2.~~2.8.4.1.2. A period of up to twelve (12) months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G).

~~2.4.4.1.2.1.~~2.8.4.1.2.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network provider at least once within the previous twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the State or by documentation from the provider or Enrollee.

~~2.4.4.1.2.2.~~2.8.4.1.2.2. Provider is willing to accept payment from the Contractor based on the Contractor's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and

~~2.4.4.1.2.3.~~2.8.4.1.2.3. Contractor would not otherwise exclude the provider from their Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

~~2.4.4.1.3.~~2.8.4.1.3. Enrollees will not be required to change nursing facilities during the duration of the Demonstration if they resided in the nursing facility prior to enrollment in MediConnect, the facility is licensed by CDPH, meets acceptable quality standards, and the facility and Contractor agree to rates in accordance with Section 2.8.4.1.2.2.

~~2.4.4.1.4.~~2.8.4.1.4. Sections 2.8.4.1.1 and 2.8.4.1.2 do not apply to providers of the following: durable medical equipment, medical supplies, transportation, other ancillary services, or carved-out services.

~~2.4.4.1.5.~~2.8.4.1.5. Contractor must inform Enrollees of its new Network Providers.

~~2.4.4.1.6.~~2.8.4.1.6. If an Enrollee receives care from an out-of-network provider, Contractor must advise the Enrollee and provider that

they have received care from an out-of-network provider that would not otherwise be covered at an in-network level.

~~2.4.4.1.7.~~2.8.4.1.7. Part D transition rules and rights will continue as provided for in current law and regulation for the entire integrated formulary associated with the Cal MediConnect Plan.

~~2.4.4.1.8.~~2.8.4.1.8. ~~The~~ DHCS will distribute an enrollment choice packet that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment choice packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

~~2.4.4.1.8.1.~~2.8.4.1.8.1. Contractors in COHS will distribute an enrollment package that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

~~2.4.4.1.9.~~2.8.4.1.9. Out of Network Reimbursement Rules – For reimbursement of out-of-network Emergency Services or Urgent Care services, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, the Health Care Professional is required to accept as payment in full by the Contractor the amounts that the Health Care Professional could collect for that service if the beneficiary were enrolled in original Medicare or Medi-Cal FFS. However, the Contractor is not required to reimburse the Health Care Professional more than the Health Care Professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the Contractor in writing that it is billing an amount less than such amount. For Emergency Services and postabilization care services, as defined by 42 C.F.R. § 438.114(a), for which Medi Cal is the primary payor, the Contractor must comply with 42 C.F.R. § 438.114 and an out-of-network provider is required to accept the applicable Medi-Cal fee-for-service payment amount as payment in full by the Contractor consistent with 42 U.S.C. § 1396u-2(b)(2)(D). Enrollees maintain balance billing protections as provided in Section 5.1.12.

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~~2.4.4.1.9.1.~~2.8.4.1.9.1. Contractors may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which the Contractor shall pay non-contracted Health Care Professionals and section 1861(u) providers of services the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers) regardless of setting and type of care for authorized out-of-network services.

~~2.8.3.1.1.~~2.8.4.1.10. If an Enrollee is receiving any service that would not otherwise be authorized by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period that the service will no longer be authorized, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

~~2.8.3.1.2.~~2.8.4.1.11. The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require prior authorization or step therapy under the Contractor's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

~~2.8.3.1.3.~~2.8.4.1.12. If Contractor's Provider Network is unable to provide necessary services covered under the Contract to a particular Enrollee, Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is otherwise unable to provide them, as required by 42 C.F.R § 438.206(b)(4).

2.9. Provider Network

2.9.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and the State to ensure adequate access to medical, Behavioral Health, pharmacy, and LTSS, excluding IHSS, and MSSP, providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.9.2. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health services, other specialty services, and all other services

required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A).

2.9.2.1. Contractor will be required to comply with 42 C.F.R. § 438.56(d)(2).

2.9.3. The Contractor must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days, following a change in Contractor's Provider Network that renders Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in Section 2.9.11.2, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

2.9.4. The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

2.9.5. The Contractor shall assure that all network providers that provide Medicare Covered Services do not appear on the CMS preclusion list in order to receive reimbursement for claims or otherwise participate in the Medicare program. Pursuant to 42 C.F.R. § 438.602(b), the Contractor shall ensure that all such providers are enrolled with DHCS as Medicaid providers consistent with the provider screening, disclosure, and enrollment requirements of 42 C.F.R. 455, subparts B and E. Payment of a portion of a Medicare Covered Service is not considered a Medicaid Covered Service for the purpose of this section.

2.9.6. The Contractor may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; this does not include IHSS providers.

2.9.7. The Contractor may also offer single-case out-of-network agreements to providers who are: 1) not willing to enroll in the Contractor's Provider Network, 2) currently serving Enrollees, 3) willing to continue serving them at the Contractor in-network rate of payment, under the following circumstances:

2.9.7.1. The Contractor's Provider Network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;

2.9.7.2. Transitioning the Enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

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2.9.7.3. Transitioning the Enrollee to another provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

2.9.8. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, person who is homeless, Enrollees with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.

2.9.8.1. Contractor shall have a cultural and linguistic services program that incorporates the requirements of California Code of Regulations Title 22 section 53876 regardless of whether it operates in a Two-Plan County. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update its cultural and linguistic services consistent with the group needs assessment requirements as specified by DHCS.

2.9.8.2. Contractor shall implement and maintain a written description of its cultural and linguistic services program, which shall include at minimum the following:

2.9.8.2.1. An organizational commitment to deliver culturally and linguistically appropriate health care services;

2.9.8.2.2. Goals and objectives;

2.9.8.2.3. A timetable for implementation and accomplishment of the goals and objectives;

2.9.8.2.4. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the community advisory committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described; and

2.9.8.2.5. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

2.9.8.3. Linguistic Capability of Employees: Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non- clinical).

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2.9.8.4. The Contractor shall educate Network Providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and federal law to communicate with Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.

2.9.8.5. The Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers, understand and comply with their obligations under Sate or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

2.9.8.6. The Contractor shall ensure that Network Providers have interpreters/translators that are available for those who are deaf or hearing-impaired within the Contractor's Service Are.

2.9.8.7. The Contractor shall ensure that its Network Providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities) and other special populations served under the Contract.

2.9.8.8. The Contractor shall ensure that its Network Providers have an understanding of disability-competent care.

2.9.8.9. Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. Section 12101 et seq.), 45 C.F.R. Part 84 and 28 C.F.R. Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

2.9.9. Provider Qualifications and Performance

2.9.9.1. All Network Providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medi-Cal programs and a valid NPI number, as applicable. Providers that have been terminated from or suspended either Medicare or Medi-Cal cannot participate in Contractor's Provider Network.

2.9.9.1.1. Contractor is responsible for the oversight of all Network Providers delivering non-Covered Services (e.g., CPO Services).

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2.9.10. Subcontracting Requirements

2.9.10.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.10.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per this Contract and 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230~~(b)(3), (4),~~ and California Code of Regulations Title 22 section 53867.

2.9.10.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and State laws and regulations, including the required contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.10.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC sections 14186 through 14186.4.

2.9.10.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

2.9.10.6. The Contractor must:

2.9.10.6.1. Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;

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2.9.10.6.2. Contract only with qualified or licensed providers who continually meet federal and State requirements, as applicable, and the qualifications contained in Appendix C**.**

2.9.10.6.3. This section does not apply to the California Department of Social Services or any other State department contracting with the Contractor for the provision of services under the Demonstration.

2.9.11. Provider Education and Training

2.9.11.1. Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures as well as the Cal MediConnect program ~~and the Contractor model of care~~.

2.9.11.2. Provider Training. Contractor shall ensure that all Network Providers receive training regarding the Cal MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations, including rights and responsibilities pertaining to Grievance and Appeals procedures and timelines under this contract. Contractor shall ensure that Network Provider training relates to Cal MediConnect services-including but not limited to the care coordination benefit, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that Network Provider training includes information on all Enrollee rights including the right to full disclosure of health care information and the right to actively participate in health care decisions. ~~The Contractor will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its Network Providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.~~

2.9.11.2.1. Contractor shall develop and implement a process to provide information to Network Providers and to train Network Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction. This process shall include an educational program for Network Providers regarding health

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needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

2.9.11.3. The Contractor will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its Network Providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

2.9.11.4. Provider Orientation. Contractor shall conduct orientation sessions for Network Providers and their office staff.

2.9.11.5. Cultural Competency Training. Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers and First Tier, Downstream and Related Entities with direct Enrollee interaction. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and, language and literacy needs including limited English proficiency; and diverse cultural and ethnic backgrounds.

2.9.11.6. Provider Manual. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, care management programs and Enrollee rights.

2.9.11.6.1. Except as otherwise required or authorized by CMS, DHCS or by operation of law, ensure that Network Providers receive thirty (30) days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Network Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

2.9.11.7. Provider Directory. Contractor shall make its Provider Directory available to Providers via Contractor's web-portal and as described in Section 2.17.5.10.

2.9.11.8. Provider-based Health Education for Enrollees. Contractor shall encourage Network Providers to provide health education to Enrollees as described in Section 2.9.11.99. Contractor shall ensure that Network Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

2.9.11.9. Health Education. Contractor shall implement and maintain a health education program that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Enrollees. This includes helping the Enrollee understand their health plan and the benefits the plan provides.

2.9.11.9.1. Contractor shall ensure administrative oversight of the health education program by a qualified full-time health educator.

2.9.11.9.2. Contractor shall provide health education programs and services at no charge to Enrollees directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Enrollee population.

2.9.11.9.3. Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Enrollees and effective in achieving behavioral change for improved health.

2.9.11.9.4. Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

2.9.11.9.5. Contractor shall maintain a health education program that provides educational interventions addressing the following health categories and topics:

2.9.11.9.5.1. Appropriate use of health care services – e.g., managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.

2.9.11.9.5.2. Risk-reduction and healthy lifestyles – e.g., tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity.

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2.9.11.9.5.3. Self-care and management of health conditions – e. g., pregnancy; asthma; diabetes; and, hypertension.

2.9.11.9.6. Contractor shall ensure that Enrollees receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for Enrollees.

2.9.11.9.7. Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness, as approved by the Contractor's quality improvement committee.

2.9.11.9.8. Contractor shall periodically review the health education program to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

2.9.11.10. Health, Safety and Welfare Education. As part of its Provider education, Contractor shall include information related to identifying, preventing and reporting abuse, neglect, exploitation, and critical incidents.

2.9.11.11. Disability Sensitivity Training. As part of its Provider education, Contractor shall provide disability sensitivity training for its medical, Behavioral Health, MSSP and CBAS providers (see Section 2.9.8.8).

2.10. Network Management

2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.

2.10.1.1. Taking into consideration:

2.10.1.1.1. The anticipated number of Enrollees;

2.10.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

2.10.1.1.3. The number and types of providers required to furnish the Covered Services;

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2.10.1.1.4. The number of Network Providers who are not accepting new patients; and

2.10.1.1.5. The geographic location of Network Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

2.10.1.2. The Contractor will work in collaboration with Network Providers to actively improve the quality of care provided to Enrollees, consistent with the quality improvement goals and all other requirements of this Contract.

2.10.1.3. The Contractor shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its Service Area are open, (e.g., Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:

2.10.1.3.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.10.1.3.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds.

2.10.1.3.3. Disconnect rate of all incoming calls not to exceed five (5) percent.

2.10.2. Access to Care Standards. The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

2.10.2.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (~~https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-~~

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~~and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html~~MMP Reference File);

2.10.2.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. § 423.120; or

2.10.2.3. For Medi-Cal providers and facilities, the Contractor contracts with a sufficient number of LTSS providers, including but not limited to SNFs (distinct part and free-standing), ~~MSSP,~~CBAS and County Social Services Agencies located in the Contractor's Service Area.

2.10.2.3.1. If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).

2.10.2.3.2. Contractor shall ensure the provision of acceptable accessibility standards in accordance with 42 C.F.R. §§ 438.206(c) and 438.68 and Title 28 CCR Section 1300.67.2.2 and as specified below.

2.10.2.4. Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medi-Cal fee-for-service, if the provider serves only Medi-Cal Enrollees.

2.10.3. Appropriate Clinical Timeframes. Except for LTSS, Contractor shall communicate, enforce, and monitor providers' compliance with these standards:

2.10.3.1. Contractor shall ensure that Enrollees are offered appointments for covered health care services within a time period appropriate for their condition.

2.10.3.2. Enrollees must be offered appointments within the following timeframes:

2.10.3.2.1. Urgent Care appointment for services that do not require prior authorization – within forty-eight (48) hours after request;

2.10.3.2.2. Urgent appointment for services that do require prior authorization within ninety-six (96) hours after request;

2.10.3.2.3. Non-urgent primary care appointments – within ten (10) business days after request;

2.10.3.2.4. Appointment with a specialist – within fifteen (15) business days after request;

2.10.3.2.5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) business days after request.

2.10.3.3. Shortening or Expanding Timeframes: Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Enrollee's medical record that a longer timeframe will not have a detrimental impact on the Enrollee's health.

2.10.3.4. Contractor will monitor providers regularly to determine compliance with the timely access requirements.

2.10.3.5. Contractor will take corrective action if it, or its providers, fail to comply with timely access requirements.

2.10.4. PCP Assignment

2.10.4.1. The Contractor will allow each Enrollee to choose his or her PCP to the extent possible and appropriate. If the Enrollee does not select a PCP within thirty (30) calendar days of the effective coverage date, Contractor shall assign that Enrollee to a PCP and notify the Enrollee and the assigned PCP in writing no later than forty (40) calendar days after the Enrollee's coverage date.

2.10.4.2. If an Enrollee does not select a PCP within thirty (30) calendar days of the effective date of coverage date, Contractor shall use FFS utilization data or other data sources, including electronic data, to:

2.10.4.2.1. Establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic, if an Enrollee indicates a preference for either. Contractor shall comply with all federal and State Privacy laws in the provision and use of this data.

2.10.4.3. Contractor shall notify the PCP that an Enrollee has selected or been assigned to the PCP within ten (10) calendar days from when selection or assignment is completed by the Enrollee or the Contractor, respectively.

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2.10.4.4. Contractor shall maintain procedures that proportionately include contracting traditional and safety-net providers in the assignment process for Enrollees who do not choose a PCP.

2.10.4.5. If, at any time, an Enrollee notifies the Contractor of a PCP choice, such choice shall override Enrollee assignment to a PCP in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5. Provider Credentialing, Recredentialing, and Board Certification

2.10.5.1. Credentialing and Recredentialing: Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including PCPs and specialists in accordance with the DHCS Policy Letter 02-03, check to see if a provider is suspended or excluded suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program pursuant to WIC section 14043.61 and 42 C.F.R. § 455.436;, and adhere to managed care standards at 42 C.F.R. § 422.204. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.1.1. Contractor shall ensure those policies and procedures are reviewed and approved by the plan governing body, or designee.

2.10.5.1.2. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.2. Credentialing Site Review: A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's Provider Network. If a provider is added to Contractor's Provider Network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5.3. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: Contractor will use procedures consistent with DHCS policy for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify CMS ninety (90) days prior of any such changes.

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2.10.6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): Contractor shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Contractor shall reimburse FQHCs and RHCs in accordance with current federal and State laws and regulations. If FQHC and RHCs services are not available in the Provider Network, Contractor shall authorize out-of-network services subject to the prevailing Medicare Advantage payment requirements for out-of-network services.

2.10.6.1. FQHC and RHCs Reimbursements: The Contractor shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of:

2.10.6.1.1. The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC and RHCs, and

2.10.6.1.2. The amount of cost-sharing that would have been paid to the FQHC for serving the Enrollee if the Enrollee were in Medicare fee-for-service, consistent with how such amounts are included in the Medi-Cal component of the Capitation Rates.

2.10.6.1.3. The intent of these provisions is to ensure that Contractors pay FQHCs and RHCs amounts consistent with Medicare and Medi-Cal managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

2.10.7. IHSS Network. Contractor shall develop and execute an MOU with County Social Services Agency responsible for IHSS that reflects an agreement between the Contractor and County Social Services Agency regarding roles and responsibilities for Cal MediConnect and IHSS. This MOU will specify the role of the county in:

2.10.7.1. Assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, in addition to sharing those assessments with the Enrollee's ICT.

2.10.7.2. Sharing confidential data regarding IHSS authorized hours and services as necessary and as permissible under applicable State and federal law.

2.10.7.3. Determining whether the Enrollees' desires to have his or her IHSS providers involved in care planning or coordination, and if so, obtain express consent from the Enrollee or his or her authorized representative.

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2.10.7.4. Support an Enrollee who is at risk for out-of-home placement in obtaining IHSS services.

2.10.7.5. Report documentation that Contractor has developed and will conduct a benefit orientation and training program specific to IHSS for First Tier, Downstream and Related Entities. The Contractor also provides documentation that it has trained personnel of IHSS organizations regarding the Contractor's Covered Services and policies and procedures to access services and coordinate care.

2.10.8. Emergency Services Programs (ESPs)

2.10.8.1. Contractor shall have, as a minimum, a designated emergency service facility, providing care on a twenty-four (24) hour-a-day, seven (7) day-a-week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

2.10.9. Emergency Care

2.10.9.1. Contractor shall cover Emergency Services without prior authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Contractor shall coordinate access to emergency care services in accordance with 42 C.F.R. § 438.114 and the Contractor's DHCS-approved emergency department protocol.

2.10.9.2. Contractor shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-emergency care.

2.10.9.3. Contractor shall ensure that a contracting physician is available twenty-four (24) hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Enrollees in an emergency department, if necessary.

2.10.9.4. Contractor may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2.10.9.5. Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's PCP, MCO, PIHP, PAHP or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.10.9.6. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

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2.10.9.7. May not deny payment for treatment obtained under either of the following circumstances:

2.10.9.7.1. An Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition.

2.10.9.7.2. The Contractor's representative instructs the Enrollee to seek Emergency Services.

2.10.9.8. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

2.10.10. Post-Stabilization Care Services

2.10.10.1. The Contractor must cover and pay for Post-Stabilization Care Services.

2.10.10.2. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Contractor's provider or other Contractor representative.

2.10.10.3. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's organization that are not pre-approved by a Network Provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.

2.10.10.4. The Contractor is financially responsible for Post-Stabilization Care Services obtained from within or outside the Contractor that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if the Contractor:

2.10.10.4.1. Does not respond to a request for pre-approval within one (1) hour;

2.10.10.4.2. Cannot be contacted; or

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2.10.10.4.3. Or the Contractor's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Network Provider is not available for consultation.

2.10.10.4.4. In this situation, the Contractor must give the treating physician the opportunity to consult with a Network Provider and the treating physician may continue with care of the Enrollee until a Network Provider is reached or one of the criteria in 42 C.F.R. § 113(c)(3) is met.

2.10.10.5. The Contractor must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Enrollee if he or she had obtained the services through the Contractor.

2.10.10.6. End of Contractor's financial responsibility. The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when:

2.10.10.6.1. A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

2.10.10.6.2. A Network Provider assumes responsibility for the Enrollee's care through transfer;

2.10.10.6.3. Contractor's representative and the treating physician reach an agreement concerning the Enrollee's care; or

2.10.10.6.4. The Enrollee is discharged

2.10.11. Long Term Services and Supports Providers Network

2.10.11.1. Contractor shall develop policies and procedures to train:

2.10.11.1.1. All Contractor staff involved in Care Coordination:

2.10.11.1.1.1. Person-centered planning processes;

2.10.11.1.1.2. Linguistic, cultural, and cognitive competence;

2.10.11.1.1.3. Core concepts of the Olmstead Decision, i.e. serving Enrollees in the least restrictive settings as appropriate;

2.10.11.1.1.4. Accessibility and accommodations; independent living;

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2.10.11.1.1.5. Wellness principles;

2.10.11.1.1.6. Criteria for safe transitions, transition planning, Care Plans after transitioning; and,

2.10.11.1.1.7. Along with other required training as specified by DHCS—both initially and on an annual basis.

2.10.11.1.2. Specially designated Care Coordination staff in dementia care management including but not limited to:

2.10.11.1.2.1. Understanding dementia;

2.10.11.1.2.2. Symptoms and progression;

2.10.11.1.2.3. Understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,

2.10.11.1.2.4. Community resources for Enrollees and caregivers.

2.10.11.1.3. Specially designated Care Coordination staff in MSSP including but not limited to:

2.10.11.1.3.1. An overview of the characteristics and needs of MSSP's target population;

2.10.11.1.3.2. MSSP's eligibility criteria;

2.10.11.1.3.3. Assessment and reassessment processes, services, and service authorization process; and,

2.10.11.1.3.4. How to refer Enrollees to MSSP for assessment and eligibility determination.

2.10.11.1.4. All Contractor staff generally on the addition of LTSS and social services to Contractor operations. For all trainings, Contractor shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

2.10.12. Women's Health Services: Contractor shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventive health care services. Such access may be in addition to the Enrollee's PCP.

2.10.13. Family Planning Provider Network

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2.10.13.1. Contractor shall cover family planning services for all Enrollees whether the family planning services are provided by contracted provider or an out-of-network provider.

2.10.13.2. Contractor agrees to abide by 42 C.F.R. § 438.206.

2.10.14. Indian Health Network: The Contractor shall permit Indian Enrollees eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as a PCP if the Indian Health Care Provider has capacity to provide such services regardless of whether the Indian Health Care Provider is in or out of network;

2.10.14.1. The Contractor shall demonstrate that there are sufficient Indian Health Care Providers in the Provider Network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services;

2.10.14.2. For services provided prior to January 1, 2018, the Contractor shall pay both network and non-network Indian Health Care Providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the DHCS fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian health care provider;

2.10.14.3. For services provided on or after January 1, 2018, the Contractor shall reimburse Indian Health Care Providers who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Contractor shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider;

2.10.14.4. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian health care provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

2.10.14.5. When the amount the in-network Indian Health Care Provider receives from the contractor is less than the amount the IHCP would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

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2.10.14.6. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians regardless of payer. The Contractor must exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

2.10.14.7. The Contractor must permit an out of network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider.

2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.1. Authorize, arrange, coordinate and provide to Enrollees all Covered Services that are Medically Necessary;

2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.2.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.11.1.2.2. Providing interpreters or translators for Enrollees who are deaf and hard of hearing and those with limited English proficiency;

2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:

2.11.1.2.3.1. Providing Braille materials and displays and large print (at least ~~18~~20 ~~6~~ point font) versions of all written materials to Enrollees with visual impairments;

2.11.1.2.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.11.1.2.3.3. Reading notices and other written materials to Enrollees upon request;

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2.11.1.2.3.4. Assisting Enrollees in filling out forms over the telephone;

2.11.1.2.3.5. Ensuring effective communication to and from Enrollees with disabilities through email, telephone, and other electronic means;

2.11.1.2.3.6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and

2.11.1.2.3.7. Individualized assistance.

2.11.1.3. The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance; and

2.11.1.4. If the Contractor's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them.

~~2.11.1.4.~~2.11.1.5. The Contractor must collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and care coordination efforts;

~~2.11.1.5.~~2.11.1.6. When a PCP or medical, Behavioral Health or LTSS provider is terminated from the Contractor's plan or leaves the Provider Network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, or no later than thirty (30) calendar days before the termination date, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provide. For terminations of PCPs, the Contractor must also report the termination to DHCS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

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~~2.11.1.6.~~2.11.1.7. Contractor shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness, or other unforeseen circumstances.

2.11.2. Contractor shall ensure Enrollee access to specialists for Covered Services that are Medically Necessary. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through subcontracts, sufficient to assure that health services will be provided in accordance with Section 2.10.2 and consistent with all specified requirements.

2.11.2.1. Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.

2.11.2.1.1. Appointments: Contractor shall implement and maintain procedures for Enrollees to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2.11.2.1.2. First Prenatal Visit: Contractor shall ensure that the first prenatal visit for a pregnant Enrollee will be available within two (2) weeks upon request.

2.11.2.1.3. Waiting Times: Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the Network Providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Section 2.11.2.1.1 appointments, above.

2.11.2.1.4. Telephone Procedures: Contractor shall require Network Providers to maintain a procedure for triaging Enrollees' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2.11.2.1.5. After Hours Calls: At a minimum, Contractor shall ensure that all Enrollees have access to appropriate licensed professional for after-hours calls.

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2.11.2.1.6. Unusual Specialty Services: Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined medically necessary.

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.3.1.2. Urgent Care sought outside of the Service Area;

2.11.3.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.11.3.1.4. Preventative services;

2.11.3.1.5. Family planning services;

2.11.3.1.6. Out-of-area renal dialysis services;

2.11.3.1.7. Basic prenatal care;

2.11.3.1.8. Sexually transmitted disease services; and

2.11.3.1.9. HIV testing.

2.11.4. The Contractor must have a mechanism in place to allow Enrollees with special health care needs to have direct access to a specialist as appropriate for the Enrollee's condition and identified needs, such as a standing referral to a specialty Provider.

2.11.5. Authorization of Services. The Contractor shall authorize services ~~i~~n accordance with 42 C.F.R. § 438.210 except for Medicare Part B drugs which shal be authorized in accordance with the timelines in Section 2.11.5.6.1.1 and 2.11.5.6.2.1.~~,~~ the Contractor shall authorize services as follows:

2.11.5.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

2.11.5.1.1. Have in place and follow written policies and procedures;

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2.11.5.1.2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;

2.11.5.1.3. Have in place procedures to allow Enrollees to initiate requests for provision of services; and

2.11.5.1.4. Consult with the requesting Network Provider when appropriate.

2.11.5.2. The Contractor shall ensure that an authorized Care Coordinator is available twenty-four (24) hours a day for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's guidelines for medical necessity must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medi-Cal standards for LTSS.

2.11.5.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.11.5.4. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for quantitative treatment limitations between Behavioral Health and medical/surgical inpatient, outpatient and pharmacy benefits.

2.11.5.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.5.5.1. Be produced in a manner, format, and language that can be easily understood;

2.11.5.5.2. Be made available in Threshold Languages, upon request;

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2.11.5.5.3. Include information, in Threshold Languages about how to request translation services and ~~alternative format~~Alternative Formats. Alternative ~~f~~Formats shall include materials which can be understood by persons with limited English proficiency: and

2.11.5.5.4. In any written communication to a physician or other health care provider of a denial, delay or modification of a request, include the name and telephone number of the health care professional responsible for the denial, delay or modification.

2.11.5.6. The Contractor must make authorization decisions in the following timeframes:

2.11.5.6.1. For standard authorization decisions~~,~~:

2.11.5.6.1.1. For Medicare Part B drugs, consistent with 42 C.F.R. § 422.568(b)(2), the Contractor shall provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours of the receipt of the request for service. No extension is permitted.

~~2.11.5.6.1.1.~~2.11.5.6.1.2. For decisions invoving all other benefits, provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably necessary to render a decision, and in all circumstances no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. The Contractor must issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. Such extension shall only be allowed if:

~~2.11.5.6.1.1.1.~~2.11.5.6.1.2.1. The Enrollee or the Provider requests an extension, or

~~2.11.5.6.1.1.2.~~2.11.5.6.1.2.2. The Contractor can justify (to the satisfaction of DHCS and/or CMS upon request) that:

~~2.11.5.6.1.1.2.1.~~2.11.5.6.1.2.2.1. The extension is in the Enrollee's interest; and

~~2.11.5.6.1.1.2.2.~~2.11.5.6.1.2.2.2. There is a need for additional information where:

~~2.11.5.6.1.1.2.2.1.~~2.11.5.6.1.2.2.2.1. There is a reasonable likelihood that receipt of such

information would lead to approval of the request, if received; and

~~2.11.5.6.1.1.2.2.2.~~2.11.5.6.1.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.5.6.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than:

2.11.5.6.2.1. For Medicare Part B drugs, consistent with 42 C.F.R. § 422.572(a)(2), the Contractor shall provide notice as expeditiously as the Enrollee's health condition requires and no later than twenty-four (24) hours of the receipt of the request for service. No extension is permitted.

~~2.11.5.6.1.2.~~2.11.5.6.2.2. For other benefits, within seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

~~2.11.5.6.1.3.~~2.11.5.6.2.3. The Enrollee or the provider requests an extension; or

~~2.11.5.6.1.4.2.10.1.1.1.1. The Contractor can justify (to DHCS and/or CMS upon request) that:~~

~~2.11.5.6.1.4.1.~~2.11.5.6.2.3.1. The extension is in the Enrollee's interest; and

2.11.5.6.2.4. The Contractor can justify (to DHCS and/or CMS upon request) that:

~~2.11.5.6.1.4.2.~~2.11.5.6.2.4.1. There is a need for additional information where:

~~2.11.5.6.1.4.2.1.~~2.11.5.6.2.4.1.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

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2.11.5.6.2.4.1.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

~~2.11.5.6.1.5.~~2.11.5.6.2.5. If, on expedited Appeal, the Contractor decides fully in the Enrollee's favor, the Contractor must provide or authorize the requested service as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours after the Contractor's receipt of the Appeal (or no later than upon expiration of an extension discussed above).

2.11.5.6.3. In accordance with 42 C.F.R. §§ 438.3(i), 438.210(e), and 422.208, compensation to individuals or entities that conduct utilization management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

~~2.10.1.1. Withdrawal of an Appeal~~

~~2.10.1.1.1. The Enrollee, Enrollee's authorized representative, or physician acting on behalf of an Enrollee who files an Appeal may withdraw it by filing a written request for withdrawal with the Contractor.~~

~~2.10.1.1.1. Effective no sooner than January 1, 2022, such withdrawal requests may also be withdrawn by a verbal request. The Contractor shall document the date, the name of the individual making the request, their relationship to the Enrollee, and the reason for withdrawal of any such verbal requests.~~

2.11.5.7. Dismissal of authorization requests.

2.11.5.7.1. The Contractor shall dismiss an authorization request, either entirely or as to any stated issue, under any of the following circumstances:

2.11.5.7.1.1. The individual or entity making the request is not permitted to request an authorization under Section 2.11.5.1~~2.8.3.2.1.1.~~

2.11.5.7.1.2. The Contractor determines the requesting party failed to make out a valid request for an authorization that substantially complies with the requirements of this section as directed by DHCS and CMS (for example, missing authorization of representation when required), and the requesting party was provided a reasonable opportunity to correct any errors or omissions in the request for authorization prior to the Contractor's determination.

2.11.5.7.1.3. An Enrollee or the Enrollee's representative files a request for an authorization, but the Enrollee dies while the request is pending, and both of the following apply:

2.11.5.7.1.3.1. The Enrollee's surviving spouse or estate has no remaining financial interest in the case; and

2.11.5.7.1.3.2. No other individual or entity with a financial interest in the case wishes to pursue the authorization request.

2.11.5.7.1.4. A party requesting the authorization submits a timely request for withdrawal of their authorization request.

2.11.5.7.2. Notice of dismissal: The Contractor must mail or otherwise transmit a written notice of the dismissal of the authorization request to the parties. The notice must state all of the following:

2.11.5.7.2.1. The reason for the dismissal.

2.11.5.7.2.2. The right to request that the Contractor vacate the dismissal action for good cause as permitted under Section 2.11.5.7.3.

2.11.5.7.2.3. The right to request reconsideration of the dismissal.

2.11.5.7.3. Vacating a dismissal: If good cause is established, the Contractor may vacate its dismissal of an authorization request within 6 months from the date of the notice of dismissal.

2.11.5.7.4. Effect of dismissal: The dismissal of an authorization request for an organization determination is binding unless it is modified or reversed by the Contractor upon reconsideration or vacated under Section 2.8.3.11.3.

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~~2.11.5.6.2.~~2.11.5.7.5. Withdrawing a request: A party that makes an authorization request may withdraw its request at any time before the decision is issued by filing a request to withdraw with the Contractor.

2.11.6. Utilization Management

2.11.6.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.6.1.1. Qualified staff responsible for the utilization management program.

2.11.6.1.2. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

2.11.6.1.3. Allowances for a second opinion from a qualified health professional at no cost to the Enrollee.

2.11.6.1.4. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

2.11.6.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

2.11.6.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

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2.11.6.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of Appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.

2.11.6.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

2.11.6.1.9. Procedures to identify, communicate, and implement actions to correct potential over and under-utilization issues that are identified.

2.11.6.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. §§ 422.112, 422.152, 422.202, and 422.4.

2.11.6.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.6.3.1. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

2.11.6.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee or its equivalent.

2.11.6.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2.11.6.3.4. Reasons for decisions are clearly documented.

2.11.6.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made.

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2.11.6.3.6. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

2.11.6.3.7. Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2.11.6.3.8. Records, including any NOA, shall meet the retention requirements described in Section 5.4 Records Retention, Inspection, and Audit.

2.11.6.3.9. Contractor must notify the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

2.11.7. Timeframes for Authorization

2.11.7.1. Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

2.11.7.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.7.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto. Retrospective review applies only to Medi-Cal services, but Contractor may at its discretion apply retrospective review to Medicare services.

2.11.7.4. Non Part D covered pharmaceuticals: Twenty-four (24) hours on all drugs that require prior authorization in accordance with WIC section 14185 or any future amendments thereto.

2.11.7.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred

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and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.6. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and not later than seventy-two (72) hours after receipt of the request for services. The Contractor may extend this period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.7. LTSS Authorization as follows:

2.11.7.7.1. Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.7.7.2. Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.7.7.3. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for ~~authorization~~ enrollment into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.1.2).

2.11.7.7.4. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker may participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

2.11.8. Review of Utilization Data

2.11.8.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to

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detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.11.9. Delegating Utilization Management Activities

2.11.9.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

2.11.10. Availability of Services

2.11.10.1. Access to Services for Emergency Conditions and Urgent Care. The Contractor must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community.

2.11.10.1.1. The Contractor must cover and pay for any services obtained for Emergency Conditions in accordance with 42 C.F.R. § 438.114(c).

2.11.10.1.2. Emergency Medical Treatment and Labor Act (EMTALA): The Contractor and Network Providers must comply with EMTALA, including the requirements for qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and, as applicable, to provide Enrollees stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.11.10.1.3. An Enrollee who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.11.10.1.4. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment.

2.11.10.1.5. The Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider, the Contractor or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

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2.12. Enrollee Services

2.12.1. Enrollee service representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding medical, behavioral, and LTSS services provided;

2.12.1.2. Be trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other ~~alternative format~~Alternative Formats;

2.12.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;

2.12.1.4. Inform callers that interpreter services are free;

2.12.1.5. Be knowledgeable about Medi-Cal, Medicare, the CFAM-MOU, and the terms of the Contract;

2.12.1.6. Be available to Enrollees to discuss and provide assistance with Enrollee Grievances and complaints;

2.12.1.7. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL and how to access those services;

2.12.1.8. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.12.1.9. Demonstrate sensitivity to culture, including disability competent care and the independent living philosophy;

2.12.1.10. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of sixth grade and below, and individualized guidance from ESRs to ensure materials are understood;

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2.12.1.11. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;

2.12.1.12. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.12.1.13.1. Enrollees' rights and responsibilities;

2.12.1.13.2. The procedures for an Enrollee to change plans or to opt out of Cal MediConnect;

2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and ~~alternative format~~Alternative Formats;

2.12.1.13.4. The identity, locations, qualifications, and availability of Network Providers;

2.12.1.13.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.12.1.13.6. Be able to direct Enrollees to the Medi-Cal Dental program for any fee-for-service dental benefits available from Medi-Cal;

2.12.1.13.7. The procedures available to an Enrollee and Network Provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Benefit Determinations (denials); and

2.12.1.13.8. Additional information that may be required by Enrollees and potential Enrollees to understand the requirements and benefits of the Cal MediConnect.

2.12.2. Enrollee Service Telephone Responsiveness

2.12.2.1. The Contractor must operate a call center during normal business hours seven (7) days a week, consistent with ~~the required Medicare Communications and Marketing Guidelines and~~ the Marketing Guidance for California Medicare-Medicaid Plans. The Enrollee must be able to speak with a live ESR, Monday through Friday, during normal business hours, consistent with the ~~required~~

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~~Medicare Communications and Marketing Guidelines and the~~ Marketing Guidance for California Medicare-Medicaid Plans. The Contractor may use alternative technologies on Saturdays, Sundays, and State and federal holidays (except New Year's Day). The Contractor's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less after the interactive voice response (IVR) system, touch-tone reponse system, or recorded greeting interaction, before reaching a live person. The Contractor must limit average hold time to no longer than two (2) minutes, with the ~~average~~ hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to no higher than five percent (5%). The disconnect rate is defined as the number of calls unexpectedly dropped divided by the total number of calls made to the customer call center. Interpreters must be available for eighty percent (80%) of incoming calls requiring an interpreter within eight (8) minutes of reaching the customer service representative and be made available at no cost to the caller. The contractor must connect eighty percent (80%) of incoming calls requiring TTY services to a TTY operator within seven (7) minutes. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.12.3. Pharmacy Technical Health Call Center

2.12.3.1. The Contractor shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submissions, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contrator's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its plans' Service Areas are open, (e.g. Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well) in accordance with 42 C.F.R. § 423.128(d)(1)(i)(B). The pharmacy technical help call center must

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meet the following operating standards in accordance with 42 C.F.R § 423.128(d)(1)(ii):

~~2.12.2.1.1.~~2.12.3.1.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

~~2.12.2.1.2.~~2.12.3.1.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds after the IVR, touch-tone response system, or recorded greeting interaction.

~~2.12.2.1.3.~~2.12.3.1.3. Disconnect rate of all incoming calls not to exceed five (5) percent. The disconnect rate is defined as the number of calls unexpectedly dropped divided by the total number of calls made to the customer call center.

~~2.4.5.~~2.12.4. Coverage Determinations and Appeals Call Center Requirements

~~2.4.5.1.~~2.12.4.1. The Contractor must operate a toll-free call center with live ESRs available to respond to Network Providers or Enrollees for information related to requests for coverage under Medicare or Medi-Cal, and Medicare and Medi-Cal Appeals (including requests for Medicare exceptions and prior authorizations). The Contractor is required to provide immediate access to requests for Medicare and Medi-Cal covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call centers. The call centers must operate during normal business hours, as specified in the ~~Medicare Communications and Marketing Guidelines and the~~ Marketing Guidance for California Medicare-Medicaid Plans. The Contractor must accept requests for Medicare or Medi-Cal coverage, including Medicare coverage determinations /redeterminations, outside of normal business hours, but is not required to have live Enrollee service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

~~2.4.5.1.1.~~2.12.4.1.1. Indicates that the mailbox is secure;

~~2.4.5.1.2.~~2.12.4.1.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

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~~2.4.5.1.3.~~2.12.4.1.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

~~2.4.5.1.4.~~2.12.4.1.4. For Appeals calls, articulates the process, information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Part D Appeal requests and thirty (30) days for other standard Appeal requests.

~~2.4.6.~~2.12.5. Enrollee Advisory Committee

~~2.4.6.1.~~2.12.5.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

~~2.4.6.1.1.~~2.12.5.1.1. Meets at least quarterly throughout the Demonstration.

~~2.4.6.1.2.~~2.12.5.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and DHCS reserve the right to review and approve Enrollee membership.

~~2.4.6.2.~~2.12.5.2. The Contractor shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by DHCS and/or CMS.

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, Grievances, or Appeals related to IHSS, Contractor must comply with the established Grievance and Appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC section 10950.

2.14. Enrollee Grievances

2.14.1. Grievance Filing -- The Contractor shall inform Enrollees that they may file a Grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services. Medicare beneficiaries may also file a Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on

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the Contractor's main web page pursuant to 42 C.F.R. § 422.504 (a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1. Reporting of plan level Grievances: Contractor shall track and report to DHCS the number and types of inquiries, complaints, Grievances, Appeals, and resolutions related to Cal MediConnect, in compliance with 42 C.F.R. § 438.416 and as described in WIC section 14182.17(e)(4)(E), in the format specified by DHCS in accordance applicable DPL(s) as indicated in Section 2.1.5. DHCS will then make the required information publicly available on DHCS' internet web site.

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a Grievance process consistent with 42 C.F.R. Part 438 Subpart F, under which Enrollees may submit their Grievance regarding all Covered Services and benefits to the Contractor. Contractor shall establish and maintain a Grievance process approved by DHCS under which Enrollees may submit their Grievances regarding all benefits and services, consistent with the Knox-Keene Act, and the regulations promulgated thereunder, Welfare and Institutions Code section 14450 and CCR, Title 22, Section 53260.

2.14.2.1.2. The Contractor must maintain written records of all Grievance activities, and notify CMS and DHCS of all internal Grievances. The Grievance record must include the name of the covered person for whom the Grievance was filed; the name of the Contractor's representative recording the grievance; a general description of the reason for the Grievance; the date received; the date of each review or, if applicable, review meeting; and resolution information including date of resolution. The Grievance record must be accessible to CMS and DHCS upon request.

2.14.2.1.3. The system must meet the following standards:

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2.14.2.1.3.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.14.2.1.3.2. Timely review of each Enrollee Grievance;

2.14.2.1.3.3. Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance;

2.14.2.1.3.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the Grievance to each Enrollee Grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and

2.14.2.1.3.5. Notice to the Enrollee of the disposition of the grievance. The Notice must meet the requirements of 42 C.F.R. § 438.408(d)(1), and must:

2.14.2.1.3.5.1. Be produced in a manner, format, and language that can be easily understood;

2.14.2.1.3.5.2. Be made available in Threshold Languages, upon request;

2.14.2.1.3.5.3. Include information, in the most commonly used languages about how to request translation services and ~~alternative format~~Alternative Formats; and

2.14.2.1.3.5.4. Include information about availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance with Enrollee Grievances and Appeals in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.14.2.1.3.6. In compliance with 42 C.F.R. § 438.406(b), procedures to ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were a subordinate of any such individual, and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

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2.14.2.1.3.6.1. A Grievance regarding denial of expedited resolutions of an Appeal.

2.14.2.1.3.6.2. Any Grievance or Appeal involving clinical issues.

2.14.2.1.3.7. In addition to Grievance logs required by Medicare and Medi-Cal rules and 42 C.F.R. § 438.416, per CA Health and Safety Code section 1368(a)(4)(B) and Title 28 CCR 1300.68(d)(8), the Contractor shall maintain a log of all Exempt Grievances. The log shall be periodically reviewed by the plan and shall include the following information for each Exempt Grievance:

2.14.2.1.3.7.1. The date of the call

2.14.2.1.3.7.2. The name of the complainant

2.14.2.1.3.7.3. The complainant's ~~member~~Enrollee identification number

2.14.2.1.3.7.4. The nature of the Grievance

2.14.2.1.3.7.5. The nature of the resolution

2.14.2.1.3.7.6. The name of the plan representative who took the call and resolved the Grievance

2.14.2.1.3.8. Notice to the Enrollee of the disposition of the Grievance.

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external Grievance for Medicare only covered benefits and services through 1-800-Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombudsman program. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main web page per 42 C.F.R. § 422.504(a)(15)(ii).

2.14.3.1. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

2.14.3.2. Consistent with Health & Safety Code Section 1368(b), Contractor, except for non-Knox Keene Act Licensed COHS plans, shall inform Enrollees that they may file an External Grievance for Medi-Cal only covered benefits and services through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, DMHC's TDD line for the

hearing and speech impaired, and DMHC's website address pursuant to Health & Safety Code Section 1368.02

2.15. Enrollee Appeals

2.15.1. Integrated Notice of Action— In accordance with 42 C.F.R. §§ 431.206, 438.404 and 42 C.F.R. §§ 422.568-572, the Contractor must give the Enrollee written notice of any Adverse Benefit Determination. Enrollees will be notified of all applicable Cal MediConnect, Medicare and Medi-Cal Appeal rights through a single notice. The form and content of the notice must be approved by CMS and DHCS. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its action.

2.15.1.1. The notice must explain:

2.15.1.1.1. The action the Contractor has taken or intends to take;

2.15.1.1.2. The reasons for the action, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

2.15.1.1.3. The citation to the regulations supporting such action

2.15.1.1.4. The Enrollee's, provider's, or authorized representative's right to file an Appeal with the Contractor and whether exhaustion of the Contractor's internal Appeal process is a prerequisite to additional external review from by Medicare, Independent Medical Review by DMHC (if applicable), or a State ~~Fair~~ Hearing;

2.15.1.1.5. Procedures for exercising Enrollee's rights to Appeal;

2.15.1.1.6. Circumstances under which expedited resolution is available and how to request it; and

2.15.1.1.7. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the plan level Appeal.

2.15.1.2. Contractor must provide a ~~member~~Enrollee notice of resolution, as expeditiously as the Enrollee's health condition requires, and:

2.15.1.2.1. For drugs covered by Medicare Part B, within seven (7) days consistent, in accordance with the timelines for such items

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described this Section and consistent with 42 C.F.R. §§ 422.568, 422.572, 422.618, and 422.619. Extensions are not permitted for any Appeals regarding Medicare Part B drugs.

~~2.15.1.1.8.~~2.15.1.2.2. For all other benefits, not exceeding thirty (30) calendar days from the day Contractor receives the Appeal, or in the case of an expedited Appeal within seventy-two (72) hours as described in Section 2.15.3.5. An Enrollee notice, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

~~2.15.1.1.9.~~2.15.1.2.3. Enrollee's right to request a State ~~Fair~~ Hearing;

~~2.15.1.1.10.~~2.15.1.2.4. How to request a State ~~Fair~~ Hearing;

~~2.15.1.1.11.~~2.15.1.2.5. Right to continue to receive benefits pending a State ~~Fair~~ Hearing;

~~2.15.1.1.12.~~2.15.1.2.6. How to request the continuation of benefits;

~~2.15.1.1.13.~~2.15.1.2.7. That Enrollee may be liable for cost of any continued benefits if the Contractor's action is upheld on Appeal;

~~2.15.1.1.14.~~2.15.1.2.8. Enrollee's right to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC with respect to any and all disputes concerning Medi-Cal based services that are medical in nature and that relate to health care service plan obligations set forth under the Knox-Keene Act and the regulations promulgated thereunder.; and

~~2.15.1.1.15.~~2.15.1.2.9. How to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC.

~~2.15.1.1.16.~~2.15.1.2.10. COHS plans that have not obtained a Knox-Keene license are not required to comply with Sections 2.15.1.2.8 and 2.15.1.2.9~~2.15.1.2.6 and 2.15.1.2.7~~ of this Contract.

~~2.15.1.2.~~2.15.1.3. For covered benefits other than Medicare Part B drugs, Contractors without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must provide the Enrollee with

written notice within two (2) calendar days of the reason for the extension and inform the Enrollee of the right to file a Grievance if they disagree with the delay; and the Contractor must make reasonable efforts to provide prompt oral notice of the delay. ~~Effective January 1, 2020,~~ Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.1.4. Written material must use easily understood language and format, be available in ~~alternative format~~Alternative Fo~~rr~~rmats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in ~~alternative format~~Alternative Formats and how to access those formats.

2.15.1.5. Withdrawal of an Appeal

2.15.1.5.1. The Enrollee, Enrollee's authorized representative, or physician acting on behalf of an Enrollee who files an Appeal may withdraw it by filing a written request for withdrawal with the Contractor.

2.15.1.5.2. Effective no sooner than January 1, 2022, such withdrawal requests may also be withdrawn by a verbal request. The Contractor shall document the date, the name of the individual making the request, their relationship to the Enrollee, and the reason for withdrawal of any such verbal requests.

2.15.2. 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.

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.15.2.3. The Contractor must maintain written records of all Appeals activities. The Appeal record must include the name of the covered person for whom the Appeal was filed; the name of the Contractor's representative recording the Appeal; a general description of the reason for the Appeal; the date received; the date of each review or, if applicable, review meeting; and resolution information for each level of Appeal including date of resolution. The Appeal record must be accessible to CMS and DHCS upon request.

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2.15.3. Medi-Cal Appeals and beneficiary protections will be maintained for Appeals regarding Medi-Cal services.

2.15.3.1. Enrollee, authorized representative, or provider may file an Appeal with the Contractor either orally or in writing. ~~The Contractor shall assist the Enrollee in confirming an oral Appeal in writing.~~

2.15.3.2. Enrollee, the Enrollee's authorized representative, or a Provider with the Enrollee's written consent, may file the oral or written Enrollee Appeal with the Contractor within sixty (60) calendar days after date of the Integrated Notice of Action.

2.15.3.3. Contractor must:

2.15.3.3.1. Timely acknowledge receipt of each Enrollee Appeal, including provide a written acknowledgemnent to the Enrollee within five (5) calendar days of receipt.

2.15.3.3.2. Ensure that oral inquiries seeking to Appeal an action are treated as Appeals and confirm those inquiries in writing unless the Enrollee or provider requests expedited resolution.

2.15.3.3.3. Provide a reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing.

2.15.3.3.4. Provide the Enrollee and representative the Enrollee's case file, including medical records, and any other documents and records free of charge. The Enrollee's case file must be provided sufficiently in advance of the resolution timeframes.

2.15.3.3.5. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

2.15.3.3.6. In compliance with 42 C.F.R. § 438.406(b), ensure that decision makers on Appeals were not involved in previous levels of review or decision-making nor a subordinate of any such individual and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.15.3.3.6.1. A denial of an Appeal based on lack of medical necessity;

2.15.3.3.6.2. A Grievance regarding denial of expedited resolution of an Appeal; or

2.15.3.3.6.3. Any Appeal involving clinical issues.

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2.15.3.4. Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and State laws and regulations, including but not limited to the following:

2.15.3.4.1. Federal Medicaid regulations governing Medi-Cal Managed Care Appeals and Medi-Cal Appeals in general, at 42 C.F.R. 431 Subpart E and 42 C.F.R. 438 Subpart F.

2.15.3.4.2. Standards for expedited review of Grievances involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01;

2.15.3.4.3. Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, and external Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code Section 1374.30) and the regulations promulgated thereunder; and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, Sections 51014.1, 51014.2, 53894, and 53858, as well as 42 C.F.R. § 431.244 related to standard and expedited fair hearings decisions;

2.15.3.4.4. Twelve (12) month continuity of care under certain circumstances. WIC section14182.17 (d)(7)(A)(ii).

2.15.3.5. Expedited internal Medi-Cal Appeals**.** Contractor shall comply with all State law and regulations pertaining to expedited Appeals, as well as the following requirements:

2.15.3.5.1. Contractor shall implement and maintain procedures as described below to resolve expedited internal Appeals for Medi-Cal services. These procedures shall be followed whenever Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.

2.15.3.5.2. Enrollee or provider may file an expedited Appeal either orally or in writing, and no additional Enrollee follow-up is required.

2.15.3.5.3. Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing.

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2.15.3.5.4. Contractor must provide an Enrollee notice as quickly as the Enrollee's health condition requires, not exceeding 72 hours from the Contractor's receipt of the Appeal.

2.15.3.5.5. Except for Appeals involving Medicare Part B drugs, Contractor without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must make reasonable efforts to provide the Enrollee prompt oral notice, and provide the Enrollee with written notice of the reason for the extension within 2 calendar days and inform the Enrollee of the right to file a Grievance if they disagree with the delay. Contractor must issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. ~~Effective January 1, 2020,~~ Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.3.5.6. Contractor must provide written notice and must make a reasonable effort to provide oral notice of expedited Appeal decision.

2.15.3.5.7. Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

2.15.3.5.8. If Contractor denies a request for expedited resolution of an Appeal, it must:

2.15.3.5.8.1. Transfer the Appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the Contractor receives the Appeal with a possible fourteen (14) day extension for Contractactors without a Knox-Keene licsense, and

2.15.3.5.8.2. Give the Enrollee prompt oral notice of the denial of a request for expedited resolution and a written notice within two (2) calendar days.

2.15.3.6. Dismissal of Appeals.

2.15.3.6.1. The Contractor may dismiss an Appeal under any of the following circumstances:

2.15.3.6.1.1. The Enrollee or entity requesting the Appeal is not a proper party to the Appeal.

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2.15.3.6.1.2. The Contractor determines that the requester failed to make a valid request for an Appeal that substantially complies with Section 2.15.3.

2.15.3.6.1.3. The Enrollee fails to request the Appeal within the timeframe in Section 2.15.3.

2.15.3.6.1.4. The Enrollee dies while a valid Appeal is pending and both:

2.15.3.6.1.4.1. The Enrollee's surviving spouse or estate has no remaining financial interest in the case; and

2.15.3.6.1.4.2. No other individual or entity with a financial interest in the case wishes to pursue the Appeal.

2.15.3.6.1.5. The party filing the Appeal request submits a timely request for withdrawal of the Appeal with Contractor.

2.15.3.6.2. Notice of dismissal: The Contractor must mail or otherwise transmit a written notice of the dismissal of the Appeal to the parties. The notice must state all of the following:

2.15.3.6.2.1. The reason for the dismissal.

2.15.3.6.2.2. The right to request that the Contractor vacate the dismissal action.

2.15.3.6.2.3. For Appeals involving Medicare services and Medicare and Medicaid overlap services, the right to request review of the dismissal by CMS Independent Review Entity.

2.15.3.6.2.4. For Appeals involving Medicaid services and severvices for which Medicare and Medicaid, the right to request a State Fair Hearing to review of the dismissal.

2.15.3.6.3. Vacating a dismissal. If good cause is established, the Contractor may vacate its dismissal of an Appeal within 6 months from the date of the notice of dismissal.

2.15.3.6.4. Effect of a dismissal: Contractor's dismissal is binding unless the enrollee or other party requests review by the CMS Independent Review Entity or a State Hearing, or if the decision is vacated under Section 2.15.3.6.3.

~~2.15.3.6.~~2.15.3.7. Responsibilities in State ~~Fair~~ Hearings Related to Medi-Cal Benefits and Services. Contractor shall comply with all

regulations and procedures regarding State ~~Fair~~ Hearings, set forth in the Manual of Policies and Procedures issued by the California Department of Social Services, pursuant to Title 22, CCR, Section 50953. Contractor shall have the following responsibilities with respect to State ~~Fair~~ Hearings that are expedited, in compliance with CDSS All County Letter 13-40.

~~2.15.3.6.1.~~2.15.3.7.1. An Enrollee, or an Enrollee's authorized representative, may request a State ~~Fair~~ Hearing either orally or in writing, consistent with 42 C.F.R. § 431.221.

~~2.15.3.7.~~2.15.3.8. Parties to an internal Medi-Cal Appeal or State ~~Fair~~ Hearing.

~~2.15.3.7.1.~~2.15.3.8.1. The parties to an internal plan Appeal or the State ~~Fair~~ Hearing related to a Medi-Cal benefit or service include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

~~2.15.3.8.~~2.15.3.9. Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor, except for non-Knox Keene Act licensed COHS plans, shall comply with all statutes, regulations and procedures regarding DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to the following requirements:

~~2.15.3.8.1.~~2.15.3.9.1. Enrollees may request an IMR regarding Medi-Cal services from DMHC within six (6) months of a denial, modification or delay of a Medi-Cal service based on Contractor's determination, in whole or in part, that the service is not medically necessary. Health & Safety Code Section 1374.30.

~~2.15.3.8.2.~~2.15.3.9.2. Enrollees shall not be required to participate in Contractor's internal Appeal process for more than thirty (30) days before applying for an IMR. Health & Safety Code Section 1368(b)(1)(A).

~~2.15.3.8.3.~~2.15.3.9.3. Enrollees whose Appeal requires expedited review pursuant to Health & Safety Code Section 1368.01 shall not be required to participate in the Contractor's Internal Grievance process for more than three (3) days before applying for an IMR. Health & Safety Code Section 1374.30(j)(3).

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~~2.15.3.8.4.~~2.15.3.9.4. Enrollees may apply for an IMR without first participating in Contractor's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for an experimental treatment was denied. Health & Safety Code Section 1368.03 and 1374.31(a); Title 28, CCR Section 1300.70.4(b)(2).

~~2.15.3.8.5.~~2.15.3.9.5. Contractor must notify Enrollee in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage. Title 28, CCR Section 1300.70.4(b); Health & Safety Code Section 1370.4(c)(1).

~~2.15.3.8.6.~~2.15.3.9.6. Enrollees may not request an IMR if a State ~~Fair~~ Hearing has already been held on the issue. Title 28, CCR Section 1300.74.30(f)(3).

~~2.15.3.8.7.~~2.15.3.9.7. If DMHC determines that Enrollee is not eligible for an IMR, the Enrollee's case will be reviewed through DMHC's consumer complaint process. Health & Safety Code Section 1368(b).

2.15.4. Medicare Appeals rights and protections will be maintained and enhanced for Medicare services only.

2.15.4.1. Federal Regulations and law will continue to govern all Medicare Appeals regarding Medicare services. As outlined in the MOU, Enrollees will continue to have access to the existing Medicare Part C and Part D Appeals processes. The Medicare Part C process is set forth at 42 C.F.R. Part 422, Subpart M and in Chapter 13 of the Medicare Managed Care Manual. The Medicare Part D process is set forth at 42 C.F.R. Part 423, Subparts M and U and in Chapter 18 of the Medicare Prescription Drug Benefit Manual.

2.15.4.2. Hospital Discharge and other Discharge Appeals

2.15.4.2.1. The Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.15.4.2.2. The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, SNF, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.15.5. Continuation of Benefits Pending an Appeal

2.15.5.1. Medicare Benefits and Services

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2.15.5.1.1. The Contractor must continue providing benefits for all prior approved non-Part D Medicare benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.15.5.1.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.5.2. Medi-Cal Benefits and Services

2.15.5.2.1. The Contractor must continue providing all prior approved Medi-Cal benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits until the completion of the hearing process, or until the Enrollee withdraws the Appeal request or fails to file timely per the timeframes in 42 C.F.R. § 438.420, whichever comes first.

2.15.5.2.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.5.6. In the event that the Enrollee pursues the Appeal in multiple forums (for example, if the Enrollee files for a State ~~Fair~~ Hearing while the IRE decision is pending) and receives conflicting decisions, the Contractor is bound by, and must act in accordance with, the decision favorable to the Enrollee or the decision closest to the Enrollee's relief requested on Appeal.

2.16. Quality Improvement Program

2.16.1. Quality Improvement (QI) Program. The Contractor shall:

2.16.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.16.1.1.1. Quality of physical health care, including primary and specialty care;

2.16.1.1.2. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation;

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2.16.1.1.3. Quality of LTSS;

2.16.1.1.4. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services;

2.16.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.16.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

2.16.2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.16.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.16.2.3. Feedback provided by Enrollees and providers in the design, planning, and implementation of its CQI activities;

2.16.2.4. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS;

2.16.2.5. Issues identified by the Contractor, DHCS and/or CMS; and

2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

2.16.3. QI Program Structure

2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement,

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and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.

2.16.3.2. The Contractor shall:

2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.16.3.2.2. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.16.3.2.3. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.16.3.2.4. Establish internal processes to ensure that the quality management activities for primary, specialty, Behavioral Health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.16 of this Contract and, in addition, the following elements:

2.16.3.2.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.16.3.2.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to DHCS;

2.16.3.2.4.3. A process to measure Provider Network and Enrollees, at least annually, regarding their satisfaction with the Contractor's plan. The Contractor shall submit a survey plan to DHCS for approval and shall submit the results of the survey to DHCS and CMS;

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2.16.3.2.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to utilization management activities, using inter-rater reliability measures;

2.16.3.2.4.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in consumer advisory boards; and

2.16.3.2.4.6. In collaboration with and as further directed by DHCS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.16.3.2.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall include the following:

2.16.3.2.5.1. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

2.16.3.2.5.2. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QI committee(s) and staff within the Contractor's organization.

2.16.3.2.5.3. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

2.16.3.2.5.4. The role, structure, and function of the Quality Improvement Committee.

2.16.3.2.5.5. The processes and procedures designed to ensure that all Covered Services that are Medically Necessary are available and accessible to all Enrollees regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services that are Medically Necessary are provided in a culturally and linguistically appropriate manner.

2.16.3.2.5.6. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to

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ensure that Enrollees are able to obtain appointments within established standards.

2.16.3.2.5.7. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

2.16.3.2.5.8. Description of the activities, including activities used by persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

2.16.3.2.5.9. A description of the mechanisms used to provide feedback to staff and providers regarding QI outcomes.

2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral Health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description as follows:

2.16.3.2.6.1. Address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers with respect to QI program;

2.16.3.2.6.2. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and utilization management.

2.16.3.2.7. Plans in Los Angeles and Orange counties must initiate QI activities for Enrollees in Medicare LTI status per Section 4.2.2.2.6.4.

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2.16.3.2.7.1. QI activities under this initiative are subject to CMT approval.

2.16.3.3. Delegation of Quality Improvement Activities

2.16.3.3.1. Contractor is accountable for all QI functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to First Tier, Downstream, and Related Entities.

2.16.3.3.2. Contractor shall maintain a system to ensure accountability for delegated QI activities, that at a minimum:

2.16.3.3.2.1. Evaluates First Tier, Downstream and Related Entity's ability to perform the delegated activities including an initial review to assure that the First Tier, Downstream, and Related Entity has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;

2.16.3.3.2.2. Ensures First Tier, Downstream, and Related Entity meets standards set forth by the Contractor and DHCS; and

2.16.3.3.2.3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

2.16.3.3.3. Submit to DHCS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DHCS and CMS:

2.16.3.3.3.1. Planned clinical and non-clinical initiatives;

2.16.3.3.3.2. The objectives for planned clinical and non-clinical initiatives;

2.16.3.3.3.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.16.3.3.3.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.16.3.3.3.5. Any issues identified by the Contractor, DHCS, Enrollees, and providers, and how those issues are tracked and resolved over time;

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2.16.3.3.3.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.16.3.3.3.7. Process for correcting deficiencies.

2.16.3.3.4. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to DHCS and CMS. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and Behavioral Health services rendered, the effectiveness of LTSS, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

2.16.3.3.5. Contractor shall develop a QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:

2.16.3.3.5.1. An Assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program, including but not limited to:

2.16.3.3.5.1.1. The collection of aggregate data on utilization;

2.16.3.3.5.1.2. The review of quality of services rendered; and

2.16.3.3.5.1.3. Outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

2.16.3.3.5.2. Consistent with 42 C.F.R. § 438.332(b), copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business, including accreditation status, any deficiencies noted, and expiration date of the accreditation. Include the corrective action plan developed to address noted deficiencies.

2.16.3.3.5.3. An assessment of First Tier, Downstream and Related Entity's performance of delegated QI activities.

2.16.3.3.6. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for

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employees who will be responsible for quality management. QI staff shall include:

2.16.3.3.6.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated Behavioral Health provider, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program; and

2.16.3.3.6.2. A qualified individual to serve as the Cal MediConnect QI Director.

2.16.4. QI Activities

2.16.4.1. Performance Measurement

2.16.4.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a), 422.152, 423.514, 438.242(a) and (b), and 330.

2.16.4.1.2. Performance improvement projects must involve:

2.16.4.1.2.1. Measurement of performance using objective quality indicators;

2.16.4.1.2.2. Implementation of systems interventions to achieve improvement in quality;

2.16.4.1.2.3. Evaluation of the effectiveness of the interventions; and

2.16.4.1.2.4. Planning and initiation of activities for increasing and sustaining improvement.

2.16.4.1.3. ~~Measurement and improvement projects shall be conducted~~ The Contactor shall perform and report the quality and utilization measures identified by CMS and DHCS and in accordance with requirements in the CFAM-MOU~~, Figure 7-1 core quality measures,~~ and as specified in this Contract, and shall include, but are not limited to:

2.16.4.1.3.1. All HEDIS, HOS and CAHPS data as articulated in the annual Reporting Requirements for HEDIS, HOS, and

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CAHPS Measures memorandum;~~, as well as all other measures specified in Figure 7-1 core quality measures of the MOU referenced above (Figure 7-1). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.~~

2.16.4.1.3.2. All Medicare-Medicaid Plan-specific measures as articulated in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and the California-Specific Reporting Requirements; and

~~2.16.4.1.3.1.~~2.16.4.1.3.3. All applicable Part C and Part D reporting sections as articulated in the Medicare Part C Reporting Requirements and the Medicare Part D Reporting Requirements.

2.16.4.1.4. The Contractor shall collect ~~annual~~ data and contribute to all Demonstration QI-related processes, as directed by DHCS and CMS, as follows:

2.16.4.1.4.1. Collect and submit to DHCS, CMS and/or CMS' contractors, at the specified frequency~~in a timely manner~~, data for the measures outlined under Section 2.16.4.1.3 of this Contract;

2.16.4.1.4.2. Contribute to all applicable DHCS and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by DHCS and CMS and rectifying those inadequacies, as directed by DHCS and CMS;

2.16.4.1.4.3. Contribute to DHCS and CMS data regarding the individual and aggregate performance of Cal MediConnect Plans with respect to the noted measures; and

~~2.16.4.1.4.2.~~2.16.4.1.4.4. Contribute to DHCS processes culminating in the publication of any additional technical or other reports by DHCS related to the noted measures.

2.16.4.1.5. The Contractor shall demonstrate how to utilize results of the measures referenced under Section 2.16.4.1.3 of this Contract ~~specified in any CMS and DHCS reporting requirements documents~~ in designing QI initiatives.

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2.16.4.2. Consumer Satisfaction Survey:

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

2.16.4.3. Quality Improvement Project (QIP) Requirements

2.16.4.3.1. The Contractor shall implement and adhere to all processes relating to the QIP requirements, as directed by DHCS and CMS, and as follows:

2.16.4.3.1.1. In accordance with 42 C.F.R. § 438.330 (b) and (d) collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified by DHCS and CMS in annual guidance provided for the upcoming Contract year;

2.16.4.3.1.2. The Contractor is required to conduct or participate in two (2) QIPS approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in no more than two (2) QIPS for each Contract.

2.16.4.3.1.2.1. One (1) QIP must be an internal quality improvement project (IQIP), the requirements of which may be met by the completion of the Medicare QIP process.

2.16.4.3.1.2.2. One (1) QIP must be a DHCS facilitated statewide collaborative in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.16.4.4. Implement the QIP requirements, in a culturally competent manner;

2.16.4.5. Evaluate the effectiveness of QIP interventions, completed in a reasonable time period as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year;

2.16.4.6. Plan and initiate processes to sustain achievements and continue improvements;

2.16.4.7. Submit to DHCS and CMS, if requested by CMS or DHCS, comprehensive written reports, using the format, submission

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guidelines and frequency specified by DHCS and CMS. Such reports shall include information regarding progress on QIP requirements, barriers encountered and new knowledge gained. As directed by DHCS and CMS, the Contractor shall present this information to DHCS and CMS, if requested, at the end of the QI requirement project cycle as determined by DHCS and CMS; and

2.16.4.8. In accordance with 42 C.F.R. § 422.152 (c), develop a Chronic Care Improvement Program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, DHCS and CMS may require them to address specific topic areas.

2.16.5. External Quality Review (EQR) Activities

2.16.5.1. The Contractor shall take all steps necessary to support the EQRO contracted by DHCS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. Contractor shall address the findings of the external review through its QI program. Contractor shall develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of Contractor's QI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in Contractor's QI program. DHCS may also require separate submission of an improvement plan specific to the findings of the EQRO. EQR activities shall include, but are not limited to the following:

2.16.5.1.1. Annual validation of performance measures reported to DHCS, as directed or calculated by DHCS;

2.16.5.1.2. Annual validation of QI projects required by DHCS and CMS; and

2.16.5.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, 42 C.F.R. Part 422, Subpart D, and 42 C.F.R. Part 423, Subpart D, and at the direction of DHCS, regarding access, structure and operations, and quality of care and services furnished to DHCS. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

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2.16.5.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum perform the following activities:

2.16.5.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.16.5.1.3.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, DHCS and CMS staff in a timely manner;

2.16.5.1.3.1.3. Serve as the liaison to the EQRO, QIO, DHCS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and DHCS in a timely manner; and

2.16.5.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or DHCS.

2.16.5.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The contractor shall maintain such documentation for a minimum of ten (10) years;

2.16.5.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or

2.16.5.1.4. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and DHCS;

2.16.5.1.5. Implementing actions, as directed by DHCS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, and CMS in subsequent years; and

2.16.5.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by DHCS and CMS.

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2.16.6. CMS-Specified Performance Measurement and Performance Improvement Projects

2.16.6.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.330.

2.16.7. Clinical Practice Guidelines

2.16.7.1. The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that are:

2.16.7.1.1. Based on valid and reliable clinical evidence or a consensus of health care professionals;

2.16.7.1.2. Consider the needs of Enrollees;

2.16.7.1.3. Developed in consultation with contracting health care professionals;

2.16.7.2. Contractor will review and update practice guidelines periodically as appropriate

2.16.7.3. Contractor will disseminate the practice guidelines to all affected providers and upon request, to Enrollees and potential Enrollees.

2.16.7.4. Delegated Credentialing: Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with:

2.16.7.4.1. Credentialing Provider Organization Certification: Contractor and their Network Providers (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA.

2.16.7.5. Contractor shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

2.16.7.6. Disciplinary Actions: Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider Appeal process.

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2.16.7.7. Health Plan Accreditation: If Contractor has received a rating of "Excellent," Commendable" or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of credentialing.

2.16.7.8. Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

2.16.7.9. Credentialing of Other Non-Physician Medical Practitioners: Contractor shall develop and maintain policies and procedures that ensure that the credentials of nurse practitioners, certified nurse midwives, clinical nurse specialists and physician assistants have been verified in accordance with State requirements applicable to the provider category.

2.16.8. The Contractor's decisions regarding UM, Enrollee education, coverage of services, and other areas included in the practice guidelines must be consistent with the Contractor's clinical practice guidelines.

2.16.9. Quality Improvement Committee: Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that Enrollees and Network Providers, who are representative of the composition of the contracted Provider Network, actively participate on the committee or medical sub-committee that reports to the QIC.

2.16.9.1. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

2.16.9.2. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

2.17. Marketing, Outreach, and Enrollee Communications Standards

2.17.1. General Marketing, Outreach, and Enrollee Communications Requirements

2.17.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, Subpart V §§ 422.2260-

422.2274~~et. seq.~~, 423.120(b) and (c), § 423.128, Subpart V §§ 423.2260-423.2274, and § 438.10, § 438.104; and the ~~Medicare Communications and Marketing Guidelines~~Marketing Guidance for California Medicare-Medicaid Plans, with the following exceptions or modifications:

2.17.1.1.1. Contractor may complete an application for enrollment from a potential Cal MediConnect Enrollee and submit it to the State Enrollment Broker;

2.17.1.1.2. If approved to participate in Streamlined Enrollment, the Contractor may collect enrollment information from a potential eligible Enrollee and submit that request to the State per Section 2.3.1.7.

2.17.1.1.3. The Contractor may refer Enrollees and potential Enrollees who inquire about Capitated Financial Alignment model eligibility or enrollment to the Enrollment Broker, although the Contractor may provide Enrollees and potential Enrollees with information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the Enrollment Broker;

2.17.1.1.4. The Contractor must make available to CMS and DHCS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or potential Enrollees;

2.17.1.1.5. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or potential Enrollees, including persons with disabilities and persons using public transportation.

2.17.1.1.6. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;

2.17.1.1.7. The Contractor does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and

2.17.1.1.8. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

2.17.1.1.8.1. The recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;

2.17.1.1.8.2. The Contractor is endorsed by CMS, Medicare, Medi-Cal, the federal government, DHCS, or similar entity.

2.17.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

2.17.2.1. Made available in ~~alternative format~~Alternative Formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.17.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments; and

2.17.2.3. Translated into Threshold Languages for all required vital materials, as specified in the Marketing Guidance for California Medicare-Medicaid Plans and annual guidance to Contractors on specific translation requirements for their Service Areas; and

2.17.2.4. Mailed with short stat~~at~~ements in non-English languages, appropriate to the Service Area, that alert Enrollees with limited with limited English proficiency to the availability of language assistance services, free of charge, and how those services can be obtained, in accordance with the requirements of 45 C.F.R Part 92 and with the ~~a multi-language insert or alternate language taglines that indicate that the Enrollee can access free interpreter services to answer questions about the plan. This message shall be written in the languages required in the Medicare Communications and Marketing Guidelines and~~ Marketing Guidance for California Medicare-Medicaid Plans ~~provisions on the multi-language insert and alternate language taglines~~. Mailed with a non-discrimination notice or statement, consistent with the requirements of 45 C.F.R. Part 92.

2.17.2.5. Distributed to the Contractor's entire Service Area, as specified in Appendix I of this Contract.

2.17.3. Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials

2.17.3.1. The Contractor must receive prior approval of all Marketing, Outreach, and Enrollee Communications in categories of materials that CMS and DHCS require to be prospectively reviewed. Review timelines for member materials will follow those as outlined in the Marketing Guidance for California Medicare-Medicaid Plans. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §§ 422.2261~~2~~(b)(3) and 423.2262~~2~~1(b)(3), and will therefore be exempt from prospective

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review and approval by both CMS and DHCS. CMS and DHCS may agree to defer to one or the other party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. Contractors must submit all materials that are consistent with the definition of marketing materials in the Marketing Guidance for California Medicare-Medicaid Plans, ~~communications materials and marketing materials at 42 C.F.R. § 422.2260,~~ whether prospectively reviewed or not, via the CMS HPMS Marketing Review Module. The Contractor that is a non-Knox-Keene licensed COHS plan shall ensure that Marketing, Outreach, and Enrollee Communications involving Medi-Cal based services are consistent with the requirements of the Knox-Keene Act and the regulations promulgated thereunder. The Contractor, unless it is a non-Knox-Keene licensed COHS plan, shall submit to DMHC any Marketing, Outreach, and Enrollee Communications required to be reviewed by DMHC pursuant to the Knox-Keene Act.

2.17.3.2. CMS and DHCS may conduct additional types of review of Contractor's Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

2.17.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.17.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.17.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or DHCS determine it is appropriate to investigate.

2.17.3.2.4. "Secret shopper" activities where CMS or DHCS request Contractor materials, such as enrollment packets.

2.17.4. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.17.4.1. The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to Enrollees or potential new Enrollees more than ninety (90) days prior to the effective date of coverage for the following Contract year except as provided in Appendix L.

2.17.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.17.5.1. Consistent with the timelines specified in the Marketing Guidance for California Medicare-Medicaid Plans, the Contractor must

provide new Enrollees with the following materials which, with the exception of the materials specified in Section 2.17.5.4, must also be provided annually thereafter:

2.17.5.1.1. An Evidence of Coverage (EOC)/Member Handbook document, or a distinct and separate notice on how to access the Member Handbook online and how to request a hard copy, as specified in the Marketing Guidance for California Medicare-Medicaid Plans~~that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. § 423.128~~; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and DHCS.

2.17.5.1.1.1. Enrollee rights (see Appendix B);

2.17.5.1.1.2. An explanation of the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.17.5.1.1.3. How to request and obtain a copy of the Enrollee's medical records, and to request that they be amended or corrected;

2.17.5.1.1.4. How to obtain access to services, including specialty, Behavioral Health, pharmacy and LTSS providers;

2.17.5.1.1.5. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.17.5.1.1.5.1. What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Care Services, with reference to the definitions in 42 C.F.R. § 438.114(a);

2.17.5.1.1.5.2. The fact that prior authorization is not required for Emergency Services;

2.17.5.1.1.5.3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.17.5.1.1.5.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract;

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2.17.5.1.1.5.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.17.5.1.1.5.6. The Post-Stabilization Care Services rules as outlined under 42 C.F.R. § 422.113(c).

2.17.5.1.2. Information about Advance Directives (at a minimum those required in 42 C.F.R. § 489.102 and 42 C.F.R. § 422.128), including Enrollee rights under the law of California; the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience; that complaints concerning noncompliance with the Advance Directive requirements may be filed with DHCS; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and that information provided must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change;

2.17.5.1.3. How to obtain assistance from ESRs;

2.17.5.1.4. How to file Grievances and internal and external Appeals, including:

2.17.5.1.4.1. Grievance, Appeal and fair hearing procedures and timeframes;

2.17.5.1.4.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

2.17.5.1.4.3. A statement that when requested by the Enrollee, benefits will continue at the Contractor level for all benefits during the Contractor Appeal process, and the Enrollee may be required to pay to DHCS the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and, how the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.17.5.1.4.4. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as DHCS or CMS may identify, including an Ombudsperson;

2.17.5.1.5. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;

2.17.5.1.6. How and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost sharing, and how transportation is provided;

2.17.5.1.7. How to change providers;

2.17.5.1.8. How to disenroll from Cal Medi-Connect voluntarily;

2.17.5.1.9. How to receive counseling and referral services that are not covered under the Contract because of moral or religious objections;

2.17.5.1.10. The structure and operation of the Contractor; and

2.17.5.1.11. The structure and operation of any physician incentive plans the Contractor may have in place.

2.17.5.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and DHCS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for Enrollees enrolled through Passive Enrollment.

2.17.5.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medi Cal, and Flexible Benefits and is consistent with the requirements in Section 2.17.5.10, or a distinct and separate notice on how to access this information online and how to request a hard copy as specified in the Marketing Guidance for California Medicare-Medicaid Plans.

2.17.5.4. A single identification (ID) card for accessing all Covered Services under the plan that uses the model document developed by CMS and DHCS.

2.17.5.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and DHCS's outpatient prescription drug benefit, or a distinct and separate notice on how to access the information online and how to request a hard copy, as specified in the Marketing Guidance for California Medicare-Medicaid Plans and that uses the model document developed by CMS and DHCS.

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2.17.5.6. The procedures for an Enrollee to change Cal MediConnect Plans or to opt out of Cal MediConnect.

2.17.5.7. The Contractor must provide the following materials to current Enrollees on an ongoing basis:

2.17.5.7.1. An ANOC that summarizes all major changes to the Contractor's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and DHCS.

2.17.5.7.2. As needed to replace old versions or upon an Enrollee's request, a single ID card for accessing all Covered Services under the Contractor;

2.17.5.7.3. The Contractor must provide all Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.17.5.8. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the Contractor must provide Enrollees with at least thirty (30) calendar days advance notice regarding certain changes to the comprehensive, integrated formulary.

2.17.5.9. The Contractor must ensure that all information provided to Enrollees and potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.17.5.9.1. Made available in large print (at least ~~18~~20~~6~~ point font) to Enrollees as an ~~alternative format~~Alternative Format, upon request, once requested this will be stored in the Enrollee's medical record;

2.17.5.9.2. For materials specified in the Medicare-Medicaid marketing guidance, available in Threshold Languages, as provided for in the Marketing Guidance for California Medicare-Medicaid Plans;

2.17.5.9.3. Written with cultural sensitivity and at an average sixth grade reading level; and

2.17.5.9.4. Available in ~~alternative format~~Alternative Fo~~m~~rmats, according to the needs of Enrollees and potential Enrollees, including ~~B~~braille, oral interpretation services in non-English languages,

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as specified in Section 2.12.1.7 of this Contract; audio~~tape~~; ASL video clips, and other alternative media, as requested.

2.17.5.10. Provider/Pharmacy ~~Network~~ Directory

2.17.5.10.1. The Contractor must comply with the following maintenance and distribution requirements:

2.17.5.10.1.1. Maintain a combined Provider/Pharmacy ~~Network d~~Directory that uses the model document developed by CMS and DHCS;

2.17.5.10.1.2. Consistent with 42 C.F.R. 438.242(b)(6), p~~P~~rovide either a print copy or a distinct and separate notice about how to access this information online or request a hard copy, as specified in the ~~Medicare Communications and Marketing Guidelines and the~~ Marketing Guidance for California Medicare-Medicaid Plans, to all new Enrollees at the time of enrollment and annually thereafter;

2.17.5.10.1.3. When there is a significant change to the network, the Contractor must ~~send a special mailing~~provide notice to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual~~, immediately~~;

2.17.5.10.1.4. The Contractor must ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d) and the Marketing Guidance for California Medicare-Medicaid Plans;

2.17.5.10.2. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy consistent with S~~s~~ection 2.11.1.6 of this Contract to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified; and

2.17.5.10.3. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Enrollees.

2.17.5.11. Content of Provider/Pharmacy Network Directory. The Provider/Pharmacy Network directory must include, at a minimum, the following information for all providers in the Contractor's Provider Network:

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2.17.5.11.1. The names, addresses, URLs and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R. § ~~422.111(h)~~422.2265, 42 C.F.R § 423.2265, C.F.R § 438.10(h) and the Marketing Guidance for California Medicare-Medicaid Plans.

2.17.5.11.2. As applicable, Network Providers with training in and experience treating:

2.17.5.11.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.17.5.11.2.2. Homeless persons;

2.17.5.11.2.3. Persons who are deaf or hard-of-hearing and blind or visually impaired;

2.17.5.11.2.4. Persons with co-occurring disorders; and

2.17.5.11.2.5. Other conditions.

2.17.5.11.3. For Behavioral Health Providers, their training in and experience treating trauma, child welfare, and substance use;

~~2.17.5.11.3.~~2.17.5.11.4. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Pacific Time) weekdays and on weekends;

~~2.17.5.11.4.~~2.17.5.11.5. As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;

~~2.17.5.11.5. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Provides, licensing information, such as license number or National Provider Identifier;~~

2.17.5.11.6. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

2.17.5.11.7. Whether the Network Provider is accepting new patients as of the date of publication of the directory;

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2.17.5.11.8. Whether the Network Provider is on a public transportation route;

2.17.5.11.9. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;

2.17.5.11.10. As applicable, whether the Network Provider has access to language line interpreters;

~~2.17.5.11.11.~~2.17.1.1.1. ~~For Behavioral Health Providers, training in and experience treating trauma, child welfare, and substance use;~~

~~2.17.5.11.12.~~2.17.5.11.11. A description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs.

2.17.5.12. The directory must include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:

2.17.5.12.1. The names, addresses, and telephone numbers of all current Network Providers and pharmacies;~~and~~

2.17.5.12.2. Whether the pharmacy provides an extended day supply of medications; and

~~2.17.5.12.2.~~2.17.5.12.3. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee services telephone line (as described in Section 2.12.2.1) for assistance in finding a convenient pharmacy.

2.18. Financial Requirements

2.18.1. Financial Viability

2.18.1.1. As specified in the DHCS Request for Solutions procurement, the Contractor must meet and maintain financial viability/standards compliance for each of the following elements:

2.18.1.1.1. Minimum Required Tangible Net Equity

2.18.1.1.1.1. Contractor at all times shall be in compliance with the Tangible Net Equity (TNE) requirements in accordance with 28 CCR 1300.76. If the Contractor does not meet TNE in a given period, the CMT shall have the power and authority to take one or more of the following sanctions against the Contractor for non-compliance:

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2.18.1.1.1.1.1. Require the Contractor to submit a Corrective Action Plan within thirty (30) days of request by the CMT;

2.18.1.1.1.1.2. Appointment of temporary management if the Contractor has repeatedly failed to meet the contractual requirements or applicable federal and State law or regulation. The Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur; and

2.18.1.1.1.1.3. Take other appropriate action as determined necessary by DHCS.

2.18.1.1.2. Contractor must provide assurances satisfactory to the State showing that its provision against the risk of financial instability is adequate to ensure that its Enrollees will not be liable for the entity's debts if the entity becomes insolvent. Contractor shall demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1.

2.18.2. Administrative costs

2.18.2.1. Contractor's administrative costs shall not exceed the guidelines established under 28 CCR section 1300.78.

2.18.2.2. Standards of Organization and Financial Soundness

2.18.2.2.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code Section 1375.1.

2.18.2.3. Working Capital Requirements

2.18.2.3.1. Contractor shall maintain a working capital and current ratio in accordance with 22 CCR 53864, which requires a TNE as defined in Title 28, Section 1300.76, or one of the following:

2.18.2.3.1.1. Current ratio of at least 1:1, or prior demonstration that the Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two (2) years, or evidence that sufficient noncurrent assets,

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which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current; or

2.18.2.3.1.2. Demonstration through its history of plan operations that the plan's arrangements for health care are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness, or enrollment growth.

2.18.2.3.2. The Contractor receiving Cal MediConnect enrollment, must demonstrate and maintain adequate working capital as required in California Health and Safety Code Section 1375.1, which requires consideration of:

2.18.2.3.2.1. The financial soundness of the Contractor's arrangements for Covered Services and the schedule of rates and charges used by the Contractor;

2.18.2.3.2.2. The adequacy of working capital; and

2.18.2.3.2.3. Arrangements with providers for the provision of Covered Services.

2.18.3. Financial Stability

2.18.3.1. Throughout the term of the Contract, the Contractor must:

2.18.3.1.1. Remain financially stable;

2.18.3.1.2. Maintain adequate protection against insolvency in an amount determined by the DMHC as described in Title 28, CCR, Section 1300.75.1.

2.18.3.1.3. Demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1 as follows:

2.18.3.1.3.1. Demonstrate through its history of operations and through projections, (which shall be supported by a statement as the facts and assumptions upon which they are based) that the Contractor's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness; and

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2.18.3.1.3.2. Attest that the Contractor's arrangements for Covered Services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

2.18.3.1.4. Demonstrate that its working capital is adequate, including provisions for contingencies;

2.18.3.1.5. Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the Contract period for which payment has been made, the continuation of benefits to subscribers and Enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered; and

2.18.3.1.6. Obtain insurance or make other arrangements:

2.18.3.1.6.1. For the cost of providing to any Enrollee covered health care services the aggregate value of which exceeds $5,000 in any year;

2.18.3.1.6.2. For the cost of Covered Services provided to its Enrollees other than through the Contractor because medical necessity required their provision before they could be secured through the Contractor; and

2.18.3.1.6.3. For not more than ninety percent (90%) of the amount by which its costs for any of its fiscal years exceed one hundred fifteen percent (115%) of its income for such fiscal year.

2.18.4. Insolvency Reserve

2.18.4.1. The insolvency reserve shall have the same definition as minimum required TNE (see 2.18.1.1.1). The minimum TNE is defined by Title 28, CCR, Section 1300.76.

2.18.4.2. According to Title 28, CCR, Section 1300.76(e), California defines TNE as net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are

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not past due; long term prepayments of deferred charges, and non-returnable deposits.

2.19. Data Submissions, Reporting Requirements, and Surveys

2.19.1. General Requirements for Data. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.19.1.1. All information CMS and DHCS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.19.1.2. Any information CMS and DHCS require to comply with all applicable federal or State laws and regulations; and

2.19.1.3. Any information CMS or DHCS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals and enrollment/disenrollment rates.

2.19.2. General Reporting Requirements. The Contractor shall:

2.19.2.1. Submit to DHCS all applicable Medi-Cal reporting requirements in compliance with 42 C.F.R. § 438.602-606.

2.19.2.2. Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514, ~~438.604, and 438.606~~and 438 et seq.

2.19.2.3. Submit to CMS and DHCS all applicable MMP reporting requirements.

2.19.2.4. Submit to CMS and DHCS all required data in accordance with the specifications, templates and time frames described in this Contract.

2.19.2.5. Report HEDIS, as well as measures related to Long-Term Services and Supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements ~~for HEDIS~~, plus additional Medi-Cal measures required by DHCS. ~~All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and DHCS.~~

2.19.2.6. Report rates for an under/over-utilization monitoring measure set based upon selected HEDIS use of service measures or any other

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standardized or DHCS-developed utilization measures selected by DHCS.

2.19.2.7. Submit additional reporting requirements as specified throughout this Contract, relevant regulation or law, or as provided through guidance.

2.19.2.8. Submit to CMS and DHCS all required reports and data in accordance with the specifications, templates, and time frames described in this Contract, unless otherwise directed or agreed to by CMS and DHCS.

2.19.2.9. Submit at the request of CMS or DHCS additional ad hoc or periodic reports or analyses of data related to the Contract.

2.19.2.10. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by DHCS in accordance with applicable DPL(s) as indicated in Section 4.13.

2.19.2.11. Submit to DHCS Part D subcontractor conflict of interest letters on an annual basis. For Part D PDE data requests, securing and submitting appropriate letter from the First Tier, Downstream Entity to address potential conflicts of interests for First Tier, Downstream Entity users that may be affiliated with Part D Contractor sponsors. Letters should indicate either (a) no affiliation or, (b) if there is affiliation, how the data will be kept separate and secure from Part D Contractor plan operations.

2.19.3. Management Information Systems Capability. The Contractor shall:

2.19.3.1. Maintain Information Systems that will enable the Contractor to meet all of DHCS's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current DHCS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following DHCS standards:

2.19.3.1.1. The capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data completeness, timeliness, reasonability, and accuracy requirements of DHCS's Encounter Data submission. Contractor shall have and maintain a System that provides, at a minimum:

2.19.3.1.1.1. Eligibility data,

2.19.3.1.1.2. Information of Enrollees enrolled in Contractor's plan,

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2.19.3.1.1.3. Provider claims status and payment data,

2.19.3.1.1.4. Health care services delivery Encounter Data,

2.19.3.1.1.5. Provider Network information, and

2.19.3.1.1.6. Financial information, as specified by DHCS.

2.19.3.2. Processes that support the interactions between financial, eligibility; provider; encounter claims; quality management/QI/utilization; and report generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

2.19.3.3. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the Contractor and DHCS and any other entity deemed appropriate by DHCS. Such files shall be transmitted to DHCS through secure FTP, HTS, or a similar secure data exchange as determined by DHCS;

2.19.3.4. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and providers to quickly and easily locate all relevant information. If directed by DHCS, establish appropriate links on the Contractor's website that direct users back to the DHCS website portal; and,

2.19.3.5. The Contractor shall cooperate with DHCS in its efforts to verify the accuracy of all Contractor data submissions to DHCS.

2.19.3.5.1. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

2.19.3.5.2. The Contractor shall demonstrate controls to maintain information integrity.

2.19.3.5.3. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DHCS.

2.19.4. Accepting and Processing Assessment Data

2.19.4.1. System Access Management and Information Accessibility Requirements

2.19.4.1.1. The Contractor shall make all systems and system information available to authorized CMS, DHCS and other agency staff as determined by CMS or DHCS to evaluate the quality and effectiveness of the Contractor's data and systems.

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2.19.4.1.2. The Contractor is prohibited from sharing or publishing CMS or DHCS data and information without prior written consent from CMS or DHCS.

2.19.5. System Availability and Performance Requirements

2.19.5.1. The Contractor shall ensure that its Enrollee and provider web portal functions and phone-based functions are available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

2.19.5.2. The Contractor shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to DHCS upon request. In the event of system failure or unavailability, the Contractor shall notify DHCS upon discovery and implement the COOP immediately.

2.19.5.3. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.20. Encounter Reporting

2.20.1. The Contractor must meet any diagnosis and encounter reporting requirements that are in place for Medicare Advantage plans and Medi-Cal managed care organizations. Furthermore, the Contractor's systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS and DHCS and updated from time to time. CMS and DHCS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.20.2. Encounter Data Submission

2.20.2.1. Contractor shall implement policies and procedures for ensuring the submission of complete, timely, reasonable, and accurate Encounter Data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements.

2.20.2.2. Contractor shall require First Tier, Downstream and Related Entities and non-contracting providers to provide claims and Encounter Data to Contractor, which allow Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure Encounter Data is

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complete, timely, reasonable, and accurate prior to submission to CMS.

2.20.2.3. Contractor shall submit complete, timely, reasonable, and accurate Encounter Data to CMS no less than monthly in the form and manner specified by DHCS and CMS. CMS will forward Encounter Data directly to the State.

2.20.2.4. Contractor shall submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by CMS and DHCS. The Contractor must also correct and resubmit denied encounters as necessary.

2.20.2.5. A percentage of the monthly capitation payments will be withheld as described in Section 4.8.1.

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3. CMS and DHCS Responsibilities

3.1. Contract Management

3.1.1. Administration. CMS and DHCS will:

3.1.1.1. Designate a CMT that will include at least one (1) contract officer from CMS and at least one (1) contract officer from DHCS authorized and empowered to represent CMS and DHCS about all aspects of the Contract. Generally, the CMS part of the team will include the State Leads from the Medicare Medicaid Coordination Office (MMCO), CMCS Medicaid ~~Regional Office~~ lead from the Medicaid & CHIP Operations Group, ~~Consortium for Medicaid and Children's Health Operations (CMCHO),~~ and an Account Manager from the Office of Program Operations & Local Engagement (OPOLE)~~Consortium for Health Plan Operations (CMHPO)~~. The CMS representative and DHCS representatives will act as liaisons between the Contractor and CMS and DHCS for the duration of the Contract. The CMT will:

3.1.1.2. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.1.3. Coordinate periodic audits and surveys of the Contractor;

3.1.1.4. Receive and respond to complaints;

3.1.1.5. Conduct regular meetings with the Contractor;

3.1.1.6. Coordinate requests for assistance from the Contractor and assign CMS and DHCS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.1.7. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or DHCS;

3.1.1.8. Inform the Contractor of any discretionary action by CMS or DHCS under the provisions of the Contract;

3.1.1.8.1. Coordinate review of marketing materials and procedures;

3.1.1.8.2. Coordinate review of Grievance and Appeals data, procedures; and

3.1.1.8.3. Review, approve, and monitor the Contractor's outreach and orientation materials and procedures.

3.1.2. Review, approve, and monitor the Contractor's complaint and Appeals procedures;

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3.1.2.1. Apply one or more of the sanctions provided in Section 5.3.13, including termination of the Contract in accordance with Section 5.5, if CMS and DHCS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

3.1.2.2. Conduct site visits as determined necessary by CMS and DHCS to verify the accuracy of reported data; and

3.1.2.3. Coordinate the Contractor's external quality reviews conducted by the EQRO.

3.1.3. Performance Evaluation. CMS and DHCS will, at their discretion:

3.1.3.1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.19 and 2.20, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and DHCS will provide the Contractor with the written results of these evaluations;

3.1.3.2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3.1.3.3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys.

3.2. Enrollment and Disenrollment Systems

3.2.1. CMS and DHCS will maintain systems to provide:

3.2.1.1. Enrollment and disenrollment -information to the Contractor;

3.2.1.2. Continuous verification of eligibility status;

3.2.1.3. Identification of individuals determined as at risk or potentially at risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 432.100 and 423.153(f); and

3.2.1.4. For counties operating under COHS, DHCS will facilitate the Contractor in its responsibility for enrollment and disenrollment activities for Cal MediConnect.

3.2.2. Customer Service Team (CST) Enrollment Broker. DHCS or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1. Develop generic materials to assist potential Enrollees in choosing whether to enroll in Cal MediConnect. Said materials shall present the Cal MediConnect in an unbiased manner to potential Enrollees eligible to select a Cal MediConnect Plan. DHCS may collaborate

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with the Contractor in developing Cal MediConnect-specific materials;

3.2.2.2. Present the Cal MediConnect in an unbiased manner to potential Enrollees or those seeking to transfer from one Cal MediConnect to another. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:

3.2.2.2.1. The rights and responsibilities of participation in Cal MediConnect;

3.2.2.2.2. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network; and the HRA, and the ICT;

3.2.2.2.3. Orientation and other Enrollee services made available by the Contractor;

3.2.2.3. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.4. Be knowledgeable about the Contractor's policies, services, and procedures; and

3.2.2.5. At its discretion, develop and implement processes and standards to measure and improve the performance of the Enrollment Broker staff. The State shall monitor the activities of the Enrollment Broker.

3.3. Demonstration Transition (Phase-Out)

3.3.1. For purposes of meeting the Demonstration phase-out requirements set forth Section III.L.4 of the MOU, DHCS and CMS agree that a phase-out plan does not need to be published on the California website for public comment if the following conditions are met:

3.3.1.1. Ongoing stakeholder engagement

3.3.1.2. Public comment related to any new or amended Medicaid waivers associated with the Demonstration

3.3.1.3. Stakeholder engagement and beneficiary testing of notifications of Enrollee coverage transitions related to the Demonstration ending

3.3.1.4. Ongoing collaboration and planning with CMS to ensure Enrollees will be successfully enrolled in a Part D plan upon termination of the Demonstration

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4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments. CMS and DHCS will each contribute to the total capitation payment. CMS and DHCS will each make monthly payments to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three (3) monthly payments for each Enrollee: one (1) amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Part A/B Component), one (1) amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from DHCS reflecting coverage of Medi-Cal services (Medi-Cal Component).

4.1.1.1. On a regular basis, CMS will provide DHCS with the Contractor-level payment information in the Medicare Plan Payment Report. The use of such information by DHCS will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, DHCS will also provide to CMS Contractor-level payment information including the Medicaid Capitation Payments.

4.1.2. Demonstration Year Dates. Capitation Rate updates will take place on January 1st of each calendar year for the Medicare components of the rates, with changes to savings percentages applicable on a Demonstration Year basis, as follows. Rate updates for the Medi-Cal component of the rates will take place at least once each calendar year. CMS and DHCS will provide the Contractor with a rate report at least annually to show applicable rates for the upcoming calendar year.

4.1.2.1. Demonstration Year Dates

Figure 4.1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017
4	January 1, 2018 – December 31, 2018
5	January 1, 2019 – December 31, 2019

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Demonstration Year	Calendar Dates
6	January 1, 2020 – December 31, 2020
7	January 1, 2021 – December 31, 2021
8	January 1, 2022 – December 31, 2022

4.2. Capitated Rate Structure

4.2.1. Underlying Rate Structure for the Medi-Cal Component

4.2.1.1. The Medi-Cal component will be paid as a single, blended rate that takes into account the relative risk of the population actually enrolled in the Contractor's Cal MediConnect Plan and is weighted accordingly.

4.2.1.1.1. For Demonstration Years 1-3, the population will be categorized into four risk adjustment population categories:

4.2.1.1.1.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.1.2. HCBS High: Enrollees identified as high utilizers of home and community-based services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.1.2.1. Enrollees who receive CBAS.

4.2.1.1.1.2.2. Enrollees who are clients of MSSP sites

4.2.1.1.1.2.3. Enrollees who receive IHSS and are classified under the IHSS program as "severely impaired" (SI).

4.2.1.1.1.3. HCBS Low: Enrollees identified as low utilizers of home and community-based services. These Enrollees are IHSS recipients and classified under the IHSS program as "not severely impaired."

4.2.1.1.1.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

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4.2.1.1.2. For Demonstration Years 4-84-7, the population will be categorized into four risk adjustment population categories:

4.2.1.1.2.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.2.2. CBAS and MSSP: Enrollees identified as utilizers of CBAS or MSSP services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.2.2.1. Enrollees who receive CBAS.

4.2.1.1.2.2.2. Enrollees who are clients of MSSP sites.

4.2.1.1.2.3. IHSS Only (no CBAS or MSSP): Enrollees identified as utilizers of IHSS services, who do not receive CBAS and are not clients of MSSP sites.

4.2.1.1.2.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.1.3. For Demonstation Year 8, the population will be categorized into three risk adjustment population categories:

4.2.1.1.3.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.3.2. CBAS Enrollees living in the community who utilize CBAS.

4.2.1.1.3.3. Other Community: Enrollees living in the community who do not utilize CBAS.

4.2.1.1.3.4.2.1.1.4. The State may, in consultation with CMS, modify the composition of the risk adjustment population categories upon its determination that such changes are appropriate. The State will inform the Contractor of any changes prior to modifying the risk adjustment population categories.

4.2.1.2. For Demonstration Year 1-7, Tthe Medi-Cal component will utilize the risk adjustment methodology in the contracts that support the 1115(a) demonstration for the eligible population. For Demonstration Year 8, the Medi-Cal component will utilize the risk

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adjustment methodology in the contracts that support the 1915(b) waiver for the eligible population.

4.2.1.2.1. The Medi-Cal component will employ the population categories described above. Relative cost factors (RCF) will be established for each of the ~~four (4) populations~~ population categories based on evaluation of the per member per month (PMPM) for each of the individual population groups, relative to the total Medi-Cal rate. As the total Medi-Cal rate incorporates incremental changes in population distribution (e.g. fewer Enrollees in institutional settings, increase in HCBS low for higher cost community well that may be more appropriately served by HCBS benefits), the calculation of the RCFs is also impacted by the assumed population distribution.

4.2.1.2.2. Contractor specific relative mix factors (RMF) will be computed through the use of RCFs and the proportion of each of the population category Enrollees in the plan. The RMFs will be computed by multiplying each Contractor's distribution of each of the population categories with the established RCFs to calculate a weighted average Contractor-specific RMF.

4.2.1.2.3. Contractor RMFs will be multiplied by the established Capitation Rate to determine the risk-adjusted Medi-Cal component payment rate.

4.2.1.3. The risk adjustment process will include three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.

4.2.1.3.1. Phase I: The risk adjustment methodology will be applied monthly and retroactively to match actual enrollment into the Contractor's Cal MediConnect Plan. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the next fiscal quarter. For example, in a county with a 12-month phase-in that begins enrollment in April 2014, this phase would last through the end of March 2015. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, there will be no Phase I.

4.2.1.3.2. Phase II: This phase will be for one (1) fiscal quarter. The risk adjustment methodology will be prospectively applied at the start of the quarter. Weighting the risk categories will be based on the preceding month to the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, in a county

with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, the county will immediately enter Phase II of the risk adjustment. The Phase II for San Mateo will be done according to a separate timeline, such that the risk adjustment methodology will be prospectively applied at the start of the Demonstration in April 2014 and again for a second quarter from July 2014 through September 2014 after which San Mateo will move into Phase III.

4.2.1.3.3. Phase III: Contractor rates will be based on a targeted relative mix of the population and will not be adjusted during the year. The first year of this phase will be the remaining period in the calendar year. Phase III for the county of San Mateo will begin with the fiscal year starting October 2014. The targeted relative mix of the population for the year would be based on enrollment in the plan leading up to the start of the phase III year and will include an assumed shift in population mix.

4.2.1.3.3.1. Specific to Phase III, a targeted relative mix will be projected by the State and its actuaries. This mix will be designed to be achievable by the Contractor, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.

4.2.1.3.3.2. If the population mix for the Contractor for the year results in a greater than 2.5% impact to the Medicaid component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the Contractor and Medicaid would share equally in any cost increases/decreases beyond the 2.5%. Actual plan gain or loss does not factor into this calculation.

4.2.1.4. With the structure as described above, DHCS and its actuaries will establish actuarially sound Capitation Rates for the contracts that support the 1115(a) demonstration or 1915(b) waiver, depending on the Demonstration year as identified in section 4.2.1.2 ~~demonstration~~ program for beneficiaries in the target population for Cal MediConnect. These rates will be consistent with 42 C.F.R. § 438.4 and reviewed by the CMS Regional Office. The CMS approved rates will serve as the baseline Medicaid costs.

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4.2.1.5. Upon request prior to and throughout the Demonstration, the State and its actuaries will provide to CMS the underlying data for the rate calculations associated with the contracts that support the 1115(a) demonstration or 1915(b) waiver, depending on the ~~d~~Demonstration Year as identified in Section 4.2.1.2.

4.2.1.6. Medicaid payment rates will be determined by applying annual savings percentages in Figure 4.2 to the applicable Capitation Rates for the contracts that support the 1115(a) demonstration or 1915(b) waiver depending on the D~~d~~emonstration Year as identified in Section 4.2.1.2.

4.2.1.7. As allowed under the rates for the contracts that support the 1115(a) demonstration or 1915(b) waiver, depending on the Demonstration Year as identified in Section 4.2.1.2, DHCS and its actuaries will calculate a range of actuarially sound capitation payment rates including lower bound and upper rates. The application of the savings percentage will apply to all rates, including any prospective or retroactive adjustments, within actuarially sound rate range.

4.2.1.8. Consistent with the Medicare rate updates at Section 4.2.2.2.6, the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect in Los Angeles and Orange counties beginning in 2017 will be considered during Medicaid rate development for 2017 and subsequent years, as applicable.

4.2.2. Underlying Rate Structure for Medicare Components of the Capitation Rate.

4.2.2.1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.5. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare FFS standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the enrolled population enrolled in each program prior to the Demonstration. The FFS county rates will generally reflect amounts published with the ~~April~~ annual Medicare Advantage Final Rate Announcement, adjusted to

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fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis ~~state~~ State rate published with the annual Medicare Advantage Final Rate Announcement, minus deductions for kidney acquisition costs (as of CY 2021), Indirect Medical Education, and user fees. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) published with the annual Medicare Advantage Final Rate Announcement, for the applicable county as of January 2015 (for CY 2014 the baseline was the 3-star county rate).

4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.2.5. If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the Cal MediConnect Plan, but will obtain the hospice service through the Medicare FFS benefit and the Cal MediConnect Plan would no longer receive the Medicare Parts A/B component for that Enrollee as described in

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this section. Medicare hospice services and hospice drugs and all other original Medicare Parts A & B services would be paid for under Medicare FFS. Cal MediConnect Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care, including with Medi-Cal and Part D benefits and any additional Flexible Benefits and supplemental benefits offered by the Cal MediConnect Plan . Cal MediConnect Plans would continue to receive the Medicare Part D component for all non-hospice covered drugs. Election of hospice servi ces does not change the Medi-Cal component unless otherwise specified in the DHCS 1915(b) waiver or 1115(a) demonstration.

4.2.2.2.6. Beginning January 2017, CMS will make an outlier adjustment for the Medicare A/B payments for non-ESRD beneficiaries served by the Contractor in Los Angeles and Orange Counties.

4.2.2.2.6.1. This adjustment will reflect the historical ratio of actual Medicare A/B FFS costs for the long term institutional (LTI) population in this county/counties to the predicted costs for this population, based on the standardized FFS county rates and the HCC risk adjustment model. This payment adjustment will be made retroactively after the end of each demonstration year, beginning in CY 2017 and going forward.

4.2.2.2.6.2. The outlier adjustment is a multiplicative factor equal to 95% of [the historical ratio minus 1 (one)] times the predicted rate for a baseline period. Specifically, the adjustment would be equal to: (the outlier adjustment percentage of 95%) times (this historical ratio from Section 4.2.2.2.6.1 minus 1 (one)) times (the standardized FFS county rate for the applicable calendar year for the applicable county) times (the average final HCC risk score for the applicable calendar year for the population that meets the criteria in Section 4.2.2.2.6.3) times (the number of member months for the applicable calendar year associated with the population that meets the criteria in Section 4.2.2.2.6.3).

4.2.2.2.6.3. This adjustment is limited to those new Cal MediConnect members who newly enroll in the CalMediConnect demonstration as of January 1, 2017, or later; were in Medicare LTI status at the time of their Cal MediConnect enrollment; and were in Medicare FFS at the time of their Cal MediConnect enrollment.

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4.2.2.2.6.4. Plans must initiate and report on corresponding quality improvement activities focused on Cal MediConnect members in Medicare LTI status per Section 2.16.3.2.7.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as CMS-estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2. The monthly Medicare Part D component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare A/B and Medi-Cal components of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section~~s~~ 4.2.1.3 herein.

4.2.3.2. Savings percentages will not be applied to the Part D Component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

Figure 4.2: Savings Percentages

	Demonstration Year 1	**Demonstration Year 2**	**Demonstration Years 3-8**
Minimum Savings Percentages	**1.00%**	**2.00%**	**4.00%**
County Specific Interim Savings Percentages: the sum of the minimum savings percentages and the county-specific addition			
Los Angeles	+ 0.00%	+ 1.50%	+ 1.50%
Orange	+ 0.42%	+ 1.50%	+ 1.50%
Riverside	+ 0.22%	+ 1.50%	+ 1.14%

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	Demonstration Year 1	Demonstration Year 2	Demonstration Years 3-8
San Bernardino	+ 0.44%	+ 1.50%	+ 1.50%
San Diego	+ 0.23%	+ 1.50%	+ 1.10%
San Mateo	+ 0.47%	+ 0.33%	+ 0.00%
Santa Clara	+ 0.23%	+ 1.45%	+ 0.95%

4.2.3.3. Limited risk corridors will be applied as described in Sections 4.3 and 4.4 on a Contractor basis and be reconciled after application of any risk adjustment methodologies and any other adjustments, as described in Section 4.2.1.2.

4.2.3.3.1. Risk corridors will be reconciled as if the Contractor had received the full quality withhold payment.

4.2.3.3.2. The application of county-specific interim savings percentages in ~~Section 4.2.3.1~~Figure 4.2. establishes the initial Capitation Rates for purposes of the risk corridor calculation for Demonstration Years 1-3, as described in Section 4.3.

4.2.3.3.3. A limited one-sided risk corridor will apply for Demonstration Years 6-8, as described in Section 4.4.

4.3. Risk Corridors for Demonstration Years 1-3

4.3.1. General Provisions

4.3.1.1. Calculation of Gains and Losses: The risk-sharing arrangement described in this section of the Contract may result in payment by the State and CMS to the Contractor or by the Contractor to the State and CMS.

4.3.1.1.1. All payments to be made by the State and CMS to the Contractor or by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.3.1.1.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Service Expenditures and Adjusted Non-Service Expenditures, as required in Section 4.3.3 All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.3.1.1.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, or by

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CMS and the state to the Contractor, as described in Section 4.3.3~~.1~~.

4.3.1.2. Two-sided risk corridors will apply for Demonstration Years 1-3.

4.3.1.3. Allowable Expenditures

4.3.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as require by Sections 4.3.3, and 2.18-2.20~~Section 2.17-2.19~~ of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.3.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement.

4.3.1.3.3. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State will jointly have the final decision on the resolution of any differences in the expendituredata reported.

4.3.1.3.4. The State and CMS reserve the right to adjust expenditures for services that are reimbursed at more than ten percent (10%) above the median reimbursement rate of all plans within a region. For the purposes of the risk corridor, the Regions are defined as the Northern Counties Region (San Mateo and Santa Clara Counties) and the Southern Counties Region (Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties).

4.3.1.3.5. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees

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that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.3.2. Risk Corridor Parameters

4.3.2.1. The Demonstration will utilize a limited down-side risk corridor and a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), intergovernmental transfers, and as if all Contractors had received the full quality withhold payment.

4.3.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.3.2.1.3.

4.3.2.1.2. Adjusted Interim Capitation Rate Revenue and Adjusted Final Capitation Rate Revenue: As described in Section 4.2.3, the application of county-specific interim savings percentages in Figure 4-2, ~~with the adjustments described in Section 4.3.2.1.6,~~ establishes the Adjusted Interim Capitation Rate Revenue. The Adjusted Final Capitation Rate Revenue is the revenue~~, with the adjustments described under Section 4.3.2.1.6,~~ that the Contractor would have received if the minimum savings percentages in Figure 4-2, rather that the county-specific interim savings percentages, were applied.

4.3.2.1.3. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.3.2.1.4. Down-Side Risk Corridor Payment/Recoupment

4.3.2.1.4.1. Losses will be compared to Contractor's underwriting profit/risk/contingency load. If losses exceed this amount, the difference of the loss less the underwriting profit/risk/contingency load shall be eligible for payment under the risk corridor. No payment shall be made for

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losses that are less than the underwriting profit/risk/contingency load.

4.3.2.1.4.2. First Band: For losses in excess of the underwriting profit/risk/contingency load, the State and CMS will make payment to the Contractor of sixty-seven percent (67%) of the loss, with the maximum CMS/State payment to the Contractor not exceeding the Adjusted Final Capitation Rate Revenue minus the Adjusted Interim Capitation Rate Revenue. The share of the payment made by the State and CMS will be as described in Section 4.3.2.1.1. All losses in excess of the CMS/State payment are the responsibility of the Contractor.

4.3.2.1.5. Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.3.2.1.5.1. First Band: The first band is equal to the difference between the Adjusted Interim Capitation Rate Revenue and the Adjusted Final Capitation Rate Revenue. For the purposes of the up-side risk corridor, for Contractors in counties where the interim saving percentage is equal to the minimum savings percentage, for the purposes of the up-side risk corridor, the Adjusted Interim Capitation Rate Revenue shall be further modified by applying savings percentages of one and a half percent (1.5%) in Demonstration Year 1, three and a half percent (3.5%) in Demonstration Year 2 and five and a half percent (5.5%) in Demonstration Years 3, where applicable, rather than one percent (1.0%), two percent (2.0%) and four percent (4.0%), respectively; this is determined by multiplying the initial Adjusted Interim Capitation Rate Revenue by (1 – the applicable 1.5%, 3.5% or 5.5% savings percentages above) / (1- Interim Savings Percentage).

4.3.2.1.5.1.1. For the portion of gains in the first band, no payment will be made by the Contractor to the State and CMS.

4.3.2.1.5.2. Second Band: The second band is the same size as the first band. For the portion of gains in the second band, the Contractor will make payment to the State and CMS of fifty percent (50%) of this portion of the gain, with the share of the payment made to the State and CMS as described in Section 4.3.2.1.1.

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4.3.2.1.5.3. Third Band: For the portion of gains greater than the upper limit of the second band, no payment will be made by the Contractor to the State and CMS.

Figure 4-3 Demonstration Years 1-3 Risk Sharing Corridor Table (for illustrative purposes only)

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Risk Corridor Band	Incremental Loss or Gain[1]	% Contractor Risk Sharing	% the State & CMS Risk Sharing	% CMS Risk Sharing	% the State Risk Sharing[2]
Loss Band 1	All Losses in Excess of Underwriting Profit/Risk/ Contingency Load	33%	67% (up to maximum not exceeding Adjusted Final Capitation Rate Revenue - Adjusted Interim Capitation Rate Revenue)	(67%) * (Medicare A/B Percent of Rate)	(67%)*(Medi-Cal Percent of Rate)
Gain Band 1	Gains ≤ (Adjusted Interim Capitation Rate Revenue – Adjusted Final Capitation Rate Revenue)[3]	100%	0%	0%	0%
Gain Band 2	Gains ≤ Band equal to size of *Gain Band 1*	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains > Upper Limit of *Gain Band 2*	100%	0%	0%	0%

[1] Loss and gain reflected on an incremental basis. Gains in Gain Bands 3 still results in risk sharing reconciliation for the gain in Gain Band 2.
[2] All State Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.
[3] The Adjusted Interim Capitation Rate Revenue is modified for counties in which the Interim Savings Percentage equals the Minimum Savings Percentage.

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4.3.3. Risk Sharing Settlement: CMS and the State shall determine a final settlement of payments made by the Contractor to CMS and the State, or by CMS and the State to the Contractor under this section. If any significant determinant of revenues or costs remains outstanding such that the timelines in this section do not apply, CMS and the State will establish reasonable timeframes for reporting payment and related final settlement timeframes.

4.3.3.1. Final settlement: CMS and the State shall determine a final settlement based on fifteen (15) months of claims run-out and an IBNR estimate.

4.3.3.1.1. For the purpose of the final settlement, the Contractor will jointly provide to CMS and the State the following within four hundred eighty (480) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the applicable Demonstration Year;

4.3.3.1.2. A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the applicable Demonstration Year, including fifteen (15) months of claims run-out;

4.3.3.1.3. The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond fifteen (15) months and any IBNR completion factors by category of service;

4.3.3.1.4. A complete and accurate report of Part D revenue and expenditure, as required under 42 C.F.R. § 423.514(a)(1) of this Contract;

4.3.3.1.5. A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care;

4.3.3.1.6. A complete and accurate report of net reinsurance costs that are included in the reported Actual Non-Service Expenditures;

4.3.3.1.7. Financial reports;

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4.3.3.1.8. Encounter Data, as required under Section ~~2.19~~2.20 of this Contract;

4.3.3.2. CMS and the State shall provide the Contractor with a final reconciliation under the risk corridor arrangement within five hundred ten (510) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. Any balance due between the Contractor and CMS and the State shall be paid within sixty (60) days of the Contractor receiving the final reconciliation from CMS and the State; and

4.3.3.3. The Contractor shall provide any additional information upon request from CMS and the State necessary to calculate Total Adjusted Expenditures.

4.4. One-sided risk corridors will be established for Demonstration Years 6-8

4.4.1. General Provisions

4.4.1.1. The Demonstration will utilize a one-sided risk corridor for Demonstration Years 6 through 8. The one-sided risk corridor is designed to limit the profits received by Cal MediConnect MMPs to a reasonable percentage of total revenue.

4.4.1.2. Calculation of Gains and Losses: The risk sharing arrangement described in this section of the Contract may result in payment by the Contractor to the State and CMS.

4.4.1.2.1. All payments made by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.4.1.2.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Non-Service Expenditures and Adjusted Service Expenditures, as required in Section 4.4.3. All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.4.1.2.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, as described in Section 4.4.3.

4.4.1.3. Allowable Expenditures

4.4.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Sections 4.4.3 and ~~and Section 2.17~~ ~~2.19~~ 2.18-2.20 of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.4.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.4.1.3.3. The State and CMS reserve the right to adjust expenditures for services that are reimbursed significantly above the median reimbursement rate of other comparable plans. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. The State and CMS will provide additional detail regarding the methodology for considering adjustments to expenditures in separate technical guidance. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.4.2. One-Sided Risk Corridor Parameters

4.4.2.1. The Demonstration will utilize a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), and intergovernmental transfers. The risk corridor will reflect the

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actual -quality withhold payment received back (i.e., earned) by the Contractor.

4.4.2.1.1. Risk Corridor Share: The Medicare and Medicaid ~~contributions to~~ share of risk corridor ~~payments or~~ recoupments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.4.2.1.2.

4.4.2.1.2. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.4.2.1.3. Up-Side Risk Corridor ~~Payment/~~Recoupment: For gains, the following bands apply:

4.4.2.1.3.1. First Band: The Contractor will retain all of the gains that are equal to or less than five percent (5%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

4.4.2.1.3.2. Second Band: DHCS/CMS and the Contractor will share that portion of the gains that is over five percent (5%) and less than or equal to seven percent (7%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with seventy-five percent (75%) retained by the Contractor and twenty percent (25%) paid to DHCS/CMS.

4.4.2.1.3.3. Third Band: DHCS/CMS and the Contractor will share that portion of the gains that is over seven percent (7%) and less than or equal to nine percent (9%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with fifty percent (50%) retained by the Contractor and fifty percent (50%) paid to DHCS/CMS.

4.4.2.1.3.4. Fourth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over nine percent (9%) and less than or equal to twelve percent (12%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with twenty-five percent (25%) retained by the Contractor and seventy-five percent (~~8~~75%) paid to DHCS/CMS.

4.4.2.1.3.5. Fifth Band: DHCS/CMS will recoup the entire portion of the gains that exceeds twelve percent (12%) of the Adjusted

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Interim Capitation Rate Revenue received by the Contractor.

Figure 4-4 Demonstration Years 6-8 Risk Sharing Corridor Table (for illustrative purposes only)

Risk Corridor Band	Incremental Gain[1]	% Contractor Gain Sharing	% State & CMS Gain Sharing	% CMS Gain Sharing	% State Gain Sharing
Gain Band 1	Gains ≤ 5%	100%	0%	0%	0%
Gain Band 2	Gains >5% and ≤7%	75%	25%	(25%) * (Medicare A/B Percent of Rate)	(25%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains >7% and ≤9%	50%	50%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 4	Gains >9% and ≤12%	25%	75%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 5	Gains >12%	0%	100%	(100%) * (Medicare A/B Percent of Rate)	(100%)*(Medi-Cal Percent of Rate)

[1] Gain reflected on an incremental basis. Gains in Gain Band 5 still results in risk sharing reconciliation for the gain in Gain Bands 2-4.

4.4.3. Risk Sharing Settlement

4.4.3.1. CMS and the State shall determine final settlement of payments made by the Contractor to CMS and the State.

4.4.3.2. Data Submission. The Contractor shall submit to DHCS and CMS, in the form and manner prescribed by DHCS and CMS, the necessary data to calculate and verify the final settlement after the end of each applicable Demonstration Year.

4.4.3.3. In the event the Contractor qualifies to make both a risk corridor payment to CMS and DHCS, as well as an MLR remittance as described in Section 4.14, the risk corridor calculation will be net of ~~an~~ the MLR remittance~~s~~.

4.5. Medicare Risk Adjustment Methodology

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4.5.1. Medicare Parts A/B: The Medicare A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for Cal MediConnect.

4.5.2. Coding Intensity Adjustment Factor

4.5.2.1. CMS will calculate calendar year 2014 rates as if the coding intensity adjustment factor were not applied, to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. Operationally CMS will still apply the coding intensity adjustment factor to the risk scores but will increase the Medicare A/B baseline for non-ESRD beneficiaries and beneficiaries with an ESRD status of functioning graft, to offset this.

4.5.2.2. In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in Section 4.5.2.4. This will apply the prevailing Medicare Advantage coding intensity adjustment, on a county-specific basis, proportional to the anticipated proportion of Cal MediConnect Enrollees in 2015 with Medicare Advantage or Cal MediConnect experience in 2014, prior to September 30, 2014.

4.5.2.3. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Cal MediConnect Enrollees, with the exception of Cal MediConnect Enrollees in Orange County given the start date of enrollment in this county.

4.5.2.3.1. For Orange County in CY 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Orange County Cal MediConnect Enrollees in 2016 with Medicare Advantage or demonstration experience prior to September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to Cal MediConnect Enrollees in Orange County.

4.5.2.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts will not be risk adjusted.

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4.5.3. Medi-Cal Component: For the Medi-Cal Component of the capitated rate, DHCS will rely on the methodology described in Section 4.2.1.3 to account for differences in risk among the eligible population.

4.6. Payment Terms

4.6.1. CMS and DHCS will each make monthly, prospective capitation payments to the Contractor, with retroactive adjustments, as applicable, as described in Sections 4.2.2.2.6.1, 4.2.2.3.1, 4.7, 4.15, and 4.16.

4.6.1.1. The Medicare Parts A/B component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts. The payment period will commence on the Contract Operational Start Date.

4.6.1.2. DHCS shall remit to the Contractor a capitation payment each month for each Enrollee that appears on the approved list of Enrollees supplied to Contractor by DHCS. The Capitation Rate shall be the amount specified in Section 4.2.1.6. The payment period for health care services shall commence on the Contract Operational Start Date.

4.6.1.2.1. DHCS will pay an IHSS interim payment on behalf of the Contractor for IHSS Provider payroll as a portion of the covered Medicaid services. ~~The IHSS interim payment will be reconciled as described in Section 4.14.3.1.~~ This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.7. Modifications to Capitation Rates. CMS and DHCS will jointly notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in Section 4.1~~5~~7.

4.7.1. Rates will be updated using a similar process for each calendar year. Subject to Section 4.7.2., changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage and Part D rate announcements will be made only if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for Cal MediConnect. Such changes may be based on the following factors: shifts in enrollment assumptions;

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changes due to litigation; changes or discrepancies in federal law and/or State policy compared to assumptions about federal law and/or State law or policy used in the development of baseline estimates; changes in coding intensity; and other factors as determined appropriate and approved by CMS and the State.

4.7.2. For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.

4.7.3. Subject to Section 4.7.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DHCS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.7.4. Changes to the savings percentages will be made if and when CMS and DHCS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines or if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate and attainable payment rates for Cal MediConnect.

4.7.5. IHSS wage adjustments may occur during Cal MediConnect. Changes to the Medi-Cal Component will be made annually by county and may be retroactively applied to account for IHSS wage adjustments that occurred during the calendar year, subject to CMS review. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.8. Quality Withhold Policy for Medi-Cal and Medicare A/B Components of the Integrated, Risk-Adjusted Rate

4.8.1. Under Cal MediConnect, both payers will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D component amounts. The withheld amounts will be repaid as earned, subject to the Contractor's performance consistent with established quality thresholds.

4.8.2. CMS and DHCS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

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4.8.3. Whether or not the Contractor has met the quality requirements in a given year will be made public, as will relevant quality results in all Demonstration Years.

4.8.4. Additional details regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology are available in the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes and California Quality Withhold Measure Technical Notes.

~~4.8.1.~~4.8.5. Withhold Measures in Demonstration Year 1

~~4.8.1.1.~~4.8.5.1. In Demonstration Year 1 of Cal MediConnect, the withhold will be 1% of the respective components of the Capitation Rate. ~~See~~ Figure 4.5 below identifies the withhold measures for Demonstration Year 1.

~~4.8.1.2.~~4.8.5.2. For Demonstration Year 1, which crosses calendar years, the Contractor will be evaluated to determine whether it has met quality withhold requirements at the end of CY 2014 and at the end of CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 4.5: Quality Withhold Measures for Demonstration Year 1

Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Assessments	CMS defined process measure	X	
Consumer Governance Board	CMS defined process measure	X	
Getting Appointments and Care Quickly	AHRQ/CAHPS	X	
Customer Service	AHRQ/CAHPS	X	
Behavioral Health Shared Accountability Policies and Procedures	State defined process measure		X
Documentation of Care Goals	State defined process measure		X
Ensuring Physical Access to Buildings, Services and Equipment	State defined process measure		X
Interaction with Care Team	State defined process measure		X

4.8.6. Withhold Measures in Demonstration Years 2-8

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~~4.8.1.3.~~4.8.6.1. The quality withhold will increase to two percent (2%) in Demonstration Year 2, three percent (3%) for Demonstration Years 3-5, and four percent (4%) for Demonstration Years 6-8.~~See Figure 4.6.~~

~~4.8.1.4.~~4.8.6.2. Payment will be based on performance on the quality withhold measures listed in Figure 4.6 below. The Contractor must report these measures according to the prevailing technical specifications for the applicable measurement year.

~~4.8.1.5.~~4.8.6.3. If the Contractor is unable to report at least three (3) of the quality withhold measures listed in Figure 4.6 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in ~~separate technical guidance~~ the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes.

Figure 4.6: Quality Withhold Measures for Demonstration Years 2 - 8

Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Encounter Data	CMS defined process measure	X	
Plan All-Cause Readmissions	NCQA/HEDIS	X	
Annual Flu Vaccine	AHRQ/CAHPS	X	
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	CMS/PDE Data	X	
Behavioral Health Shared Accountability Process Measure (DY 3 Only)	State-defined process measure		X
Behavioral Health Shared Accountability Outcome Measure	State-defined measure		X
Documentation of Care Goals	State defined process measure		X
Interaction with Care Team	State defined process measure		X
Care Plan Completion (DY 6-8 Only)	CMS defined process measure		X

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~~1. CMS and DHCS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.~~

~~2.4.7. Whether or not the Contractor has met the quality requirements in a given year will be made public, as will relevant quality results in all Demonstration Years.~~

4.9. Shared Financial Accountability Strategy for Incentive Payments for Behavioral Health Services

4.9.1. Shared accountability between the Cal MediConnect Plan and county Behavioral Health agencies aims to promote Care Coordination to ensure Enrollees have access to all needed services. Shared accountability builds on the performance-based quality withhold from the plans' Capitation Rates of one percent, two percent, three percent, and four percent (1%, 2%, 3%, and 4%) in years one, two, three through five, and six through eight of the Demonstration. By meeting specified quality measures, the Contractor can earn back the withheld capitation revenue by meeting specified quality objectives. Under this shared accountability strategy, one (1) withhold measure in year one, one (1) withhold measure in year two, two (2) withhold measures in year three, and one (1) withhold measure in years four through eight will be tied to Behavioral Health coordination with the county.

4.9.2. The Contractor will be required to share with the applicable county Behavioral Health agencies a minimum amount of funds earned back through the shared accountability quality withhold measure each year. Contractor may choose to go above and beyond this minimum. This must be executed as directed in future guidance from DHCS.

4.9.3. The Contractor must provide an incentive payment each year to the county Behavioral Health agency that is equal to or greater than the value of each quality withhold measure multiplied by the proportion of Enrollees identified as having Behavioral Health needs and who are receiving county services. The proportion is defined as follows:

4.9.3.1. The denominator will be the total number of Enrollees with mental illness or substance use disorders, as defined for the emergency department reduction quality withhold measure for Years 2 through 8. The numerator would be the subset of those Enrollees who are receiving services through the county Behavioral Health agency.

4.9.3.2. In all counties except Los Angeles, the mental health and substance use departments are administratively combined. In Los Angeles County, the proportion of Enrollees with substance use disorders receiving county drug and alcohol services would be calculated separately from the Enrollees with mental illness

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population to identify the incentive payment amount paid to the Department of Public Health.

4.9.3.3. Assuming successful completion and equal weighting of each measure, total Behavioral Health shared accountability incentive payments in each year would equal:

4.9.3.3.1. Year 1 Measure A = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.9.3.3.2. Year 1 Measure B = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.9.3.3.3. Year 2: ED Measure = 0.002 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.9.3.3.4. Year 3-8: ED Measure = 0.003 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.10. Medicare A/B Disenrollment Penalty

4.10.1. Beginning in Demonstration Year 5 (CY 2019) CMS will implement a retrospective financial penalty in the Medicare A/B component of the Capitation Rate for Contractors with high disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect Demonstration and to align incentives for Contractors to improve quality for all Enrollees.

4.10.2. Performance will be evaluated annually using the existing Medicare Part C measure entitled “Members Choosing to Leave Plan.” For DYs 5 and 6, CMS intends to maintain the benchmark at the median Contractor performance from measurement year 2017. For DYs 7 and 8, CMS will set the benchmark at the median Contractor performance from the most recent measurement year. Contractors with rates above the benchmark will be subject to the penalty on a sliding scale, starting at one percent (1%) and up to two percent (2%). Additional detail regarding the methodology will be provided in separate technical guidance.

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4.10.3. Based on Contractor performance, CMS will recoup the Medicare A/B penalty retroactively, once performance for the applicable Demonstration year has been determined.

4.11. American Recovery and Reinvestment Act of 2009. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.12. Suspension of Payments. DHCS shall suspend payments to Cal MediConnect in accordance with 42 C.F.R. § 455.23 as as determined necessary or appropriate by DHCS.

4.13. Non-Payment and Reporting of Provider Preventable Conditions. Pursuant to 42 C.F.R. § 438.3(g), all payments to the Contractor are conditioned on the Contractor's compliance with all provisions related to Provider Preventable Conditions in accordance with the applicable DPL(s) as indicated in Section 2.1.5.

4.14. Medical Loss Ratio (MLR)

4.14.1. For Medicaid rating periods beginning on or after July 1, 2017, the Contractor is required to calculate and report their MLR experience for Medicaid lines of business, consistent with the requirements ~~at~~ set forth in 42 C.F.R. §§ 438.4, 438.5, 438.8 and 438.74, unless a joint MLR covering both Medicare and Medicaid experience is calculated and reported consistent with CMS and DHCS requirements.

4.14.2. Prior to the applicability of the requirements in Section 4.4.1 for all Demonstration Years in which the risk corridor applies, the Medicare Advantage MLR requirements are waived. To the extent the risk corridor ceases prior to the applicability of the requirements in Section 4.4.1 the Medicare Advantage MLR requirements will be reinstated for any applicable years in which the risk corridor is not in effect.

4.15. Risk Score Changes

4.15.1. Medicare Risk Score Changes: Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.16. Reconciliation

4.16.1. CMS and DHCS will implement a process to reconcile enrollment and capitation payments for the Contractor that will take into consideration the following circumstances: transitions between RCs; retroactive changes in eligibility, RCs, or Enrollee contribution amounts; changes in CMS-HCC and RxHCC risk scores; and changes through new

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enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

4.16.2. Identified Overpayments

4.16.2.1. The Contractor shall promptly report to DHCS and CMS any such identified overpayments due to Fraud.

4.16.2.2. The Contractor shall report to DHCS and CMS within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the ~~c~~Contract.

4.16.2.3. Recoveries by the Contractor of overpayments to providers~~.~~: Consistent with Section 1128J(d) of the Social Security Act, the Contractor must adopt and implement policies for the treatment of recoveries of overpayments from the Contractor to a ~~Network~~ Provider.

4.16.3. Medi-Cal Component Reconciliation~~.~~: The Medi-Cal Component reconciliation will occur a minimum of once a month. The monthly reconciliation process will reconcile retroactively up to twelve (12) months of historical enrollment changes or up to the effective date of the contract, whichever is sooner.

4.16.3.1. The Contractor is at full risk for IHSS Provider payments. On a quarterly basis, DHCS shall reconcile Actual IHSS expenditures against the IHSS Interim Payment. If Actual IHSS expenditures exceed the Interim Payment amount, DHCS shall invoice the Contractor for the difference with a thirty (30) day due date. DHCS shall pay California Department of Social Services within two (2) weeks of receipt from the Contractor. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.16.4. Medicare Capitation Reconciliation: Medicare capitation reconciliation will comply with prevailing Medicare Advantage regulations and processes.

4.16.4.1. Final Medicare Reconciliation and Settlement: In the event the Contractor terminates or non-renews this Contract, CMS' final settlement phase for terminating contracts applies. This final settlement phase lasts for a minimum of eighteen (18) months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to joint Medicare A/B-Medicaid risk corridors, quality

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withholds, and medical loss ratios, as applicable, that are outstanding at the time of termination.

4.16.5. Audits/Monitoring: CMS and DHCS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and DHCS.

4.17. Payment in Full

4.17.1. The Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

4.17.2. Notwithstanding any contractual provision or legal right to the contrary, the three (3) parties to this Contract (CMS, DHCS, and the Contractor), for Cal MediConnect agree there shall be no redress against either of the other two (2) parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.17.3. By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the federal government to the Contractor, any entity participating in Cal MediConnect must rely on their own resource to project likely experience under Cal MediConnect.

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5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes. The Contractor must notify CMS and DHCS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and DHCS in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The Contractor must notify CMS and DHCS in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and DHCS which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractors

5.1.3.1. The Contractor, its employees, First Tier, Downstream, and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents, or employees of the federal government, or DHCS.

5.1.3.2. The Contractor must ensure it evaluates the prospective First Tier, Downstream, and Related Entities' abilities to perform activities to be delegated, as provided for in Appendix C.

5.1.4. Subrogation. Subject to CMS and DHCS lien and third-party recovery rights, the Contractor must:

5.1.4.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer for other than Medi-Cal and Medicare covered benefits, to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

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5.1.4.2.1. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.2.2. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations. In accordance with 42 U.S.C. § 1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

5.1.6. Disclosure Requirements. The Contractor must disclose to CMS and DHCS information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain federally required disclosures from all Network Providers and applicants in accordance 42 C.F.R. § 1002.3, and as specified by DHCS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DHCS in accordance with this Contract and relevant State and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. In addition, the Contractor shall make the information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to its Enrollees upon reasonable request.

5.1.7. Physician Incentive Plans.

5.1.7.1. The Contractor and its First Tier, Downstream, and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.3(i), and 1003. The Contractor must submit all information required to be disclosed to CMS and the DHCS in the manner and format specified by CMS

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and the DHCS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the DHCS that results from the Contractor's or its First Tier, Downstream, or Related Entities' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and the DHCS, that it has made a good faith effort to comply with the cited requirements. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).

5.1.7.3. Contractor may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.

5.1.7.4. Contractor must provide information on its PIP to any Enrollee upon request as provided in 42 C.F.R. § 422.208.

5.1.7.5. Special Contract Provisions Related to Payment

5.1.7.5.1. Contractor must reimburse Network Providers pursuant to the terms of each applicable Directed Payment Initiative approved in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each Directed Payment Initiative available on the DHCS website.

5.1.7.5.2. Contractor must comply with the terms of ~~any~~the COVID-19 Vaccination Incentive Program ~~Incentive~~ Arrangement~~s~~ approved by CMS under 42 CFR section 438.6(b)(2), and the applicable rate certification, in a form and manner specified by DHCS through APL~~s~~ 21-010, Section "Incentive Program Structure", subsection "Process and Outcomes Measures", or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website. ~~-~~Incentive arrangements must comply with the following:

5.1.7.5.2.1. May not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.

5.1.7.5.2.2. Are for a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.

5.1.7.5.2.3. May not be renewed automatically.

5.1.7.5.2.4. Made available to both public and private contractors under the same terms of performance.

5.1.7.5.2.5. Does not condition participation in the incentive arrangemnent on the Contractor entering into or adhering to intergovernmental transfer agreements.

~~5.1.7.3.1.1.~~ Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy at § 438.340.

~~5.1.7.3.2.~~

5.1.8. Physician Identifier. The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The Contractor must provide such unique identifier to CMS and DHCS for each of its PCPs in the format and time-frame established by CMS and DHCS in consultation with the Contractor.

5.1.9. Timely Provider Payments. The Contractor must make timely payments to its Network Providers consistent with 42 C.F.R. § 447.45. The Contractor must ensure that ninety percent (90%) of claims from Network Providers (including Indian Health Care Providers) who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine percent (99%) of all clean claims from Network Providers will be paid within ninety (90) days of the date of receipt of the claim. The Contractor and its Network Providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

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5.1.9.1. Pharmacy providers will be reimbursed in accordance with the prompt payment provisions at 42 C.F.R. § 423. 505(i)(3)(vi).

5.1.9.2. The Contractor shall pay ninety-five percent (95%) of clean claims from non-contracted providers within thirty (30) days of request. All other claims shall be paid or denied within sixty (60) days of request.

5.1.10. Provider Payments. The Contractor shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits, per WIC Section 14182.16 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

5.1.10.1. Medi-Cal Alignment. The Contractor shall pay providers, including institutional providers, in accordance with the prompt payment provisions in compliance with 42 C.F.R. § 447.45, ARRA 5006(d) and as contained in each Contractor's Medi-Cal managed care contract with DHCS, including the ability to accept and pay electronic claims, excluding Part D.

5.1.10.2. Date of Receipt. The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.10.3. Nursing Facility Rates. The Contractor shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services. The Contractor shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

5.1.11. Protection of Enrollee-Provider Communications. In accordance with 42 USC § 1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

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5.1.12. Protecting Enrollee from Liability for Payment. The Contractor must:

5.1.12.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.12.1.1. Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.12.1.2. Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or DHCS for such services; or

5.1.12.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

5.1.12.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A below;

5.1.12.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge; and

5.1.12.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

5.1.13. Third Party Liability (TPL)

5.1.13.1. General Requirements.

5.1.13.1.1. Coordination of Benefits means the process of utilizing TPL resources to ensure that Medi-Cal is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or the method of post-payment recovery of the cost of services, if the coverage is identified retroactively.

5.1.13.1.2. DHCS shall refer to the Contractor the Enrollee's name and pertinent information where DHCS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

5.1.13.1.3. The Contractor shall identify and notify the DHCS's TPL and Recovery Division of all instances or cases in which Contractor believes an action by the Enrollee involving casualty insurance

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or tort or Workers' Compensation liability of a third party could result in recovery by the Enrollee of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, WIC. Contractor shall make no claim for recovery of the value of Covered Services rendered to an Enrollee in such cases or instances and such case or instance shall be referred to State's TPL Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

5.1.13.1.3.1. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an Enrollee, Contractor shall deliver the requested information within thirty (30) calendar days of the request. Service information includes First Tier, Downstream, or Related Entity and out of plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to First Tier, Downstream, or Related Entity providers or out of plan providers for similar services, whichever is applicable under WIC Section 14124.90(c)(2).

5.1.13.1.3.2. Designate a TPL Benefit Coordinator who shall serve as a contact person for benefit coordination issues related to this Contract.

5.1.13.1.3.3. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

5.1.14. Medicaid Drug Rebate

5.1.14.1. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.

5.1.14.2. Contractor shall submit to DHCS, on a timely and periodic basis, no later than forty-five (45) calendar days after the end of each quarterly rebate period, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as DHCS determines necessary.

5.1.5. Moral or Religious Objections. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, pay for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

5.1.5.1. To the State;

5.1.5.2. With its application for a contract;

5.1.5.3. Whenever it adopts the policy during the term of the Contract; and the information provided must be:

5.1.5.3.1. Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.5.3.2. Provided to Eligible Beneficiaries before and during enrollment; and

5.1.5.3.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.2. Confidentiality

5.2.5. Statutory Requirements. The Contractor understands and agrees that CMS and DHCS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., Parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal information under the California Information Practices Act (Civil Code Section 1798 et seq.). The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C. § 552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

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5.2.6. Personal Data. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

5.2.7. Data Security. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. § 164.530(c). The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, subpart C, the HIPAA Security Rule. Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

5.2.8. Return of Personal Data. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or DHCS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or DHCS will destroy such data or material.

5.2.9. Research Data. The Contractor must seek and obtain prior written authorization from CMS and DHCS for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.3. General Terms and Conditions

5.3.1. Applicable Law. The term "applicable law," as used in this Contract, means, without limitation, all federal and California law, and the regulations, policies, procedures, and instructions of CMS and DHCS all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity. Nothing in this Contract will be construed to be a waiver by the State of California or CMS of its rights under the doctrine of

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sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medi-Cal program.

5.3.4. Loss of Licensure. If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or State approvals, the Contractor must report such loss to CMS and DHCS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification. The Contractor shall indemnify and hold harmless CMS, the federal government, and DHCS from and against any and all liability, loss, damage, costs, or expenses which CMS and or DHCS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1. The Contractor is notified of any claims within a reasonable time from when CMS and DHCS become aware of the claim; and

5.3.5.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

5.3.6. Prohibition against Discrimination.

5.3.6.1. In accordance with 42 USC § 1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the Contractor: from including providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees; from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

5.3.6.2. Contractor will give written notice of the reason for its decision when it declines to include individual or groups of providers in its network.

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5.3.6.3. If a Complaint or claim against the Contractor is presented to DHCS or CMS, the Contractor must cooperate with in the investigation and disposition of such Complaint or claim.

5.3.7. Anti-Boycott Covenant. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by DHCS. Without limiting such other rights as it may have, CMS and DHCS will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one percent (51%) of the ownership interests of the Contractor.

5.3.8. Other Contracts. Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health Care Plans or providing health care services to persons other than those eligible for coverage in the Contract; provided, however, that the Contractor must provide CMS and DHCS with a complete list of such plans and services, upon request. CMS and DHCS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or DHCS from contracting with other comprehensive health care plans~~C~~, or any other provider, in the same Service Area.

5.3.9. Counterparts. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.10. Entire Contract. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.11. No Third-Party Rights or Enforcement. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.12. Corrective Action Plan. If, at any time, CMS and DHCS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and DHCS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and DHCS will approve, disapprove, or

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require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by CMS and DHCS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and DHCS or other intermediate sanctions as described in Section 5.3.13.

5.3.13. Intermediate Sanctions.

5.3.13.1. In addition to termination under Section 5.5, CMS and DHCS may, impose any or all of the sanctions in Section 5.3.13 upon any of the events below; provided, however, that CMS and DHCS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. CMS and DHCS may choose to provide warning notices and/or corrective action plans before sanctions. Sanctions may be imposed in accordance with this section for any failure to comply with this Contract, including but not limited to, if the Contractor:

5.3.13.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.13.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.13.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, or uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.13.1.4. Misrepresents or falsifies information provided to CMS, DHCS, Enrollees, or its Provider Network;

5.3.13.1.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.13.1.6. Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

5.3.13.1.7. Violates restrictions or other requirements regarding marketing;

5.3.13.1.8. Fails to comply with quality management requirements consistent with Section 2.16;

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5.3.13.1.9. Fails to comply with any corrective action plan required by CMS and DHCS;

5.3.13.1.10. Fails to comply with financial solvency requirements;

5.3.13.1.11. Fails to comply with reporting requirements; or

5.3.13.1.12. Fails to comply with any other requirements of this Contract.

5.3.13.2. Such sanctions may include, but are not limited to:

5.3.13.2.1. Intermediate sanctions and civil monetary penalties consistent with 42 C.F.R. § 422 Subpart O or § 438 Subpart I;

5.3.13.2.2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);

5.3.13.2.3. Suspension of enrollment (including assignment of Enrollees);

5.3.13.2.4. Suspension of payment to the Contractor;

5.3.13.2.5. Disenrollment of Enrollees; and

5.3.13.2.6. Suspension of marketing.

5.3.13.2.7. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.13.3. If CMS or DHCS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.12, CMS and DHCS may:

5.3.13.3.1. Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and DHCS; or

5.3.13.3.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

5.3.13.4. Additional Administrative Procedures. CMS and DHCS may, from time to time, issue program memoranda, bulletins, and DPLs clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda, bulletins, and letters as may be issued from time to time.

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5.3.13.5. Effect of Invalidity of Clauses. If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

~~5.3.13.5.~~5.3.13.6. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. CMS and the State must adjust the capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If CMS or the State paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to CMS or the State, respectively. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and CMS or the State included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

5.3.14. Before imposing any intermediate sanctions, consistent with 42 C.F.R. § 438.710, DHCS and CMS must give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DHCS and CMS elect to provide.

5.3.15. Conflict of Interest. Neither the Contractor, nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and DHCS with the performance of services under the Contract, or that may be otherwise anticompetitive. The Contractor further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.16. Insurance for Contractor's Employees. The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including but not limited to, worker's compensation and unemployment compensation, and must provide CMS and DHCs with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor

must, at the request of CMS or DHCS, provide certification of professional liability insurance coverage.

5.3.17. Waiver. The Contractor, CMS, or DHCS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or DHCS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and DHCS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.18. Section Headings. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audit

5.4.1. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years from the end of the final contract period or completion of audit, whichever is later.

5.4.2. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and DHCS and other regulatory agencies, available to CMS and DHCS and its agents, designees or contractors or any other authorized representatives of the State of California or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

5.4.3. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.4. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DHCS may require, in a manner that meets CMS and DHCS record maintenance requirements.

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5.4.5. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and State requirements.

5.4.6. Disputes. The Disputes procedure set forth in Appendix K will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

5.5. Termination of Contract

5.5.1. Termination without Prior Notice. –In the event the Contractor substantially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Medi-Cal programs, CMS or DHCS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract in accordance with regulations that are current at the time of the termination.

5.5.2. Without limiting the above, if CMS or DHCS determine that participation of the Contractor in the Medicare or Medi-Cal program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Medi-Cal program, CMS or DHCS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor, and shall be taken upon a finding by CMS or DHCS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medi-Cal services to Medicare-Medi-Cal beneficiaries.

5.5.3. United States law and California law, as appropriate, will apply to resolve any claim of breach of this Contract.

5.5.4. Termination with Prior Notice.

5.5.4.1. CMS or DHCS may terminate this Contract without cause upon no less than one hundred eighty (180) days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.8, the Contractor may choose to non-renew this Agreement prior to the end of each term pursuant to 42 C.F.R. § 422.506(a). In considering requests for termination under 42 C.F.R. § 422.508, CMS and DHCS will consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. §

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422.506(a) must be submitted to and approved by CMS and DHCS prior to their use.

5.5.4.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in Section~~paragraph~~ 5.5.4.1 and non-renewal of this Contract as described in Section 5.8 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

5.5.5. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.6. Termination for Cause. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or DHCS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or DHCS may expedite the termination.

5.5.6.1. Pre-termination Procedures. Before terminating a contract under 42 C.F.R. § 422.510 and § 438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or DHCS must:

5.5.6.1.1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.6.1.2. Notify the Contractor of its Appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.

5.5.6.2. If Contractor fails to comply with the provisions of Section 5.5, CMS or DHCS may terminate this agreement upon thirty days' notice.

5.5.7. Termination due to a Change in Law. ~~-~~In addition, CMS or DHCS may terminate this agreement upon thirty (30) days notice due to a material change in law, or by operation of law, including a change in the State law authorizing the State's participation in the program, or with less or no notice if required by law.

5.5.8. Continued Obligations of the Parties.

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5.5.8.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Medi-Cal programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that CMS and DHCS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.5.8.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.8.2.1. If CMS or DHCS, or both, elect to terminate the Contract, CMS and DHCS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care under applicable laws, regulations, and provisions of this Contract. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements and the terms of this Contract;

5.5.8.2.2. The Contractor must promptly return to CMS and DHCS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

5.5.8.2.3. The Contractor must supply to CMS and DHCS all information necessary for the payment of any outstanding claims determined by CMS and DHCS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6. Impact of Termination

5.6.1. In the event this Contract is terminated, expires, or is not renewed for any reason, the State shall have the authority to crosswalk Enrollees into a Medi-Cal Managed Care Plan for the purposes of the seamless provision of Medi-Cal managed care Covered Services.

5.6.2. The State shall provide such Enrollees with notice of this crosswalk and of any options Enrollees have to change Medi-Cal managed care plans for the provision of Medi-Cal Covered Services.

5.7. Order of Precedence

5.7.1. The following documents are incorporated into and made a part of this Contract:

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5.7.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;

5.7.1.2. DHCS's ~~Bridge to Health Reform~~ Medi-Cal 2020 Section 1115(a) demonstration and~~1115~~ 1915(b) ~~waiver~~ program as amended for purposes of this demonstration;

5.7.1.3. CFAM-MOU, a document between CMS and DHCS regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27, 2013);

5.7.1.4. The Contractor's Medi-Cal managed care contract, as applicable;

5.7.1.5. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, the annual rate report, plan letters, bulletins and guidance memoranda.

5.7.1.6. The Contractor's response to the Request for Solutions.

5.7.2. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

5.7.2.1. The Contract terms and conditions, including all appendices;

5.7.2.2. Capitated Financial Alignment Application;

5.7.2.3. DHCS's ~~Bridge to Health Reform~~ Medi-Cal 2020 Section 1115(a) demonstration and subsequent ~~1115~~ 1915(b) ~~waiver~~ waiver program as amended for purposes of this demonstration;

5.7.2.4. CFAM-MOU, a document between CMS and DHCS Regarding a federal-State partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27. 2013);

5.7.2.5. The Contractor's Medi-Cal managed care contract, as applicable.;

5.7.2.6. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, bulletins, and guidance memoranda; and

5.7.2.7. The Contractor's response to the RFS.

5.7.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.8. Contract Term.

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5.8.1. This Contract shall be in effect starting from the date on which all parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2022, so long as the Contractor has not provided CMS and the State with a notice of intention not to renew, and CMS/State have not provided the Contractor with a notice of intention not to terminate, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above This contract will terminate, or its effectuation will be delayed, unless the State receives all necessary approvals from CMS, including but not limited to ~~§ 1191~~915(a~~b~~) 1915(b) ~~demonstration~~ authority, and unless the Contractor is deemed ready to participate in the MMCO demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until the State has received all necessary approvals from CMS. No payments will be made nor Medicaid federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary ~~§ 1191~~915(a~~b~~) 1915(b) authority, the Readiness Review approval, or the effective date of this Contract.

5.9. Amendments

5.9.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of all three parties, and attached hereto.

5.10. Written Notices

5.10.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services

~~Medicare-Medicaid Coordination Office~~

~~7500 Security Boulevard, S3-13-23~~

~~Baltimore, MD 21244~~

To: California Department of Health Care Services

~~1501 Capitol Avenue, MS 0000, P.O. Box 997413~~

~~Sacramento, CA 95899-7413~~

To: [Legal entity name and address]

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E-mail Copies to:

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Contractor:

_____ _____

TYPE NAME AND TITLE HERE Date

<MMP Name>

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

_____ _____

~~Jennifer Kent~~Michelle Baass, Director Date
California Department of Health Care Services

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

_____ _____

Lindsay Barnette~~Richard Allen~~ Date
Director
~~Division of Medicaid Field Operations West~~Models, Demonstrations and Analysis Group
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

_____	_____
Kathryn Coleman	Date
Director	
Medicare Drug & Health Plan Contract Administration Group	
Centers for Medicare & Medicaid Services	
United States Department of Health and Human Services	

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SECTION 6: Appendices

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Appendix A: Covered Services

The Contractor shall provide services to Enrollees as follows:

A.1 Medical Necessity. The Contractor shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Covered Services that are Medically Necessary as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1. Prevent, diagnose, or treat health impairments;

A.1.2.2. Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.

A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1. Developed with input from practicing physicians in the Cal MediConnect's Service Area;

A.1.5.2. Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3. Developed in accordance with the definition of Medical Necessity in Section 2.4;

A.1.5.4. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5. Evidence-based, if practicable; and

A.1.5.6. Applied in a manner that considers the individual health care needs of the Enrollee.

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A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components must, at a minimum, be submitted to DHCS annually for approval no later than sixty (60) days prior to the start of a new Contract Year, and no later than sixty (60) days prior to any change.

A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received CMS and DHCS approval.

A.2 Covered Services. Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All standard Medi-Cal fee-for-service benefits excluding:

A.2.1.1. ICF/~~MR~~ IDD services;

A.2.1.2. County-administered Medi-Cal Specialty Mental Health Services and substance use disorder services. This does not include Behavioral Health services that become Medi-Cal managed care benefits on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, which will be Covered Services under this contract;

A.2.1.3. State and County activities to administer IHSS, including determining eligibility, assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, enrolling providers, conducting provider orientation, and retaining enrollment documentation, conducting criminal background checks on all potential providers, providing assistance to IHSS recipients in finding eligible providers through an established provider registry;

A.2.1.3.1 For dates of service on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97);

A.2.1.3.2. For dates of service on or before December 31, 2021. MSSP is no longer a Covered Service under this Contract for service dates on or after January 1, 2022, pursuant to Section 403 of the W&I Code Section 14186 (A.B. 133).

A.2.1.4. Medi-Cal Dental Services, known as Denti-Cal

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

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A.2.4 All services provided under Medicare Part D

A.2.5 Particular pharmacy products that are covered by Medi-Cal and may not be covered under Medicare Part D.

A.2.6 Contractors are encouraged to offer a broader drug formulary than minimum requirements.

A.3 In addition, Contractor agrees to provide the following:

A.3.1 Vision Benefit

A.3.1.1. $0 copay for one (1) routine eye exam every year

A.3.1.2. Every two years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses

A.3.2 Non-Medical Transportation and Non-Emergency Medical Transportation Benefits

A.3.2.1. Contractors must provide transportation services to beneficiaries for Medically Necessary Services.

A.3.2.2. Contractors must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare & Institutions Code 14132(ad) and the requirements in applicable current and future DPLs.

A.3.3 Care Transitions Assistance provided across facility and community settings. Care Coordination shall be provided for transitions among levels of care and between service locations. Such services facilitate safe and coordinated transitions across care settings, which may be particularly appropriate for Enrollees who have experienced or are expecting an inpatient stay.

A.4 Cost-sharing for Covered Services

A.4.1 Except as described below, cost-sharing of any kind is not permitted in Cal MediConnect.

A.4.1.1. Co-pays charged by Demonstration Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.4.1.2. The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

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A.4.1.3. Co-pays charged by Demonstration Plans for supplemental dental benefits.

A.5 Limitations on Covered Services.

A.5.1 – Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.5.2 –Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

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Appendix B: Enrollee Rights

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the CFAM-MOU. Specifically, Enrollees must be guaranteed:

A. The right to be treated with dignity and respect.
B. The right to be afforded Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
D. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
E. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
F. Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
G. The right to choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.
H. The right to participate in all aspects of care and to exercise all rights of Appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:
    a. Receive a comprehensive Health Risk Assessment upon date of coverage in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination of Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
    b. Receive complete and accurate information on his or her health and Functional Status by the interdisciplinary team.
    c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a

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culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
    i. Before enrollment.
    ii. At enrollment.
    iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
e. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
f. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

I. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
J. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
K. Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the DHCS treat the Enrollee.
L. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and, the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.
M. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.
N. The right not to be charged any cost sharing for Medicare Parts A and B services.
O. The unconditional and exclusive right to hire, fire, and supervise his or her IHSS provider.
P. The right to receive their Medicare and Medi-Cal Appeals rights in a format and language understandable and accessible to them.
Q. The right to opt out of Cal MediConnect at any time, beginning at the first of the following month.

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Appendix C: Relationship with First Tier, Downstream, and Related Entities

A. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§422.504, 423.505, and 438.3(k).
B. Contractor shall specifically ensure:
   1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
   2. HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
C. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
   1. Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;
   2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and DHCS; including the requirements at 42 C.F.R. § 438.414 in relation to the Grievance system.
   3. Language that specifies the delegated activities and reporting requirements;
   4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, DHCS or the Contractor determine that such parties have not performed satisfactorily;
   5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;
   6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and
   7. Language that specifies the First Tier, Downstream and Related Entities must comply with all federal and State laws, regulations and CMS instructions.
D. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:
   1. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Contractor; or
   2. The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.
E. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

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F. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.
G. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:
    1. Language that the Contractor is obligated to pay contracted medical providers under the terms of the contract between the Contractor and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant medical provider;
    2. Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
    3. Language that medical providers abide by all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
    4. Language that medical providers ensure that medical information is released in accordance with applicable federal or State law, or pursuant to court orders or subpoenas;
    5. Language that medical providers maintain Enrollee records and information in an accurate and timely manner;
    6. Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and
    7. Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.
    8. Language that clearly states the medical providers' EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
    9. Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.
    10. Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
        (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or
        (b) Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient.
    11. Language that states the provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection

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with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.

12. Language that specifies the term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.
13. Full disclosure of the method and amount of compensation or other consideration to be received from the Contractor.
14. Language that requires the medical provider to assist Contractor in the transfer of care.
15. Language that requires the medical provider to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.
16. Notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.
17. Assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
18. Timely gather, preserve and provide to DHCS, any records in the subcontractor's possession.
19. Provide interpreter services for Enrollees at all provider sites.
20. Right to submit a Grievance and Contractor's formal process to resolve Provider Grievances.
21. To participate and cooperate in the Contractor's Quality Improvement System.
22. If Contractor delegates Quality Improvement activities, Subcontract shall include provisions as specified by DHCS.

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Appendix D: Quality Improvement Requirements

The Contractor will undertake the following quality improvement initiatives with the goal of identifying areas in need of improvement and undertaking quality improvement activities in response to the findings related to each initiative.

1. Emergency Department utilization. The goal of this initiative is to better understand reasons for ED utilization among Cal MediConnect Enrollees, and the impact of LTSS to such usage.
    - Contractor will identify a random sample of Enrollees each year who have utilized ED services.
    - Contractor will engage an independent quality assurance entity to conduct interviews with each Enrollee in the sample to determine background & causes for ED visits, using a semi-structured interview tool provided by DHCS.
    - Contractor will analyze results of the surveys in order to understand the underlying causes of ED utilization, including the use of and/or or failure of LTSS, or there was a lack of appropriate LTSS to adequately support the Enrollee in his or her environment. Contractor will identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency department services.
    - Contractor will report results to DHCS and to CMS.
2. Barriers to Health Access. The goal of this initiative is to better understand access issues experienced by Cal MediConnect Enrollees.
    - Contractor will identify a random representative sample size of Enrollees each year.
    - An independent quality assurance entity will conduct interviews with each Enrollee in the sample, using a semi-structured interview tool provided by DHCS, to determine if any barriers to health care were experienced and to understand the nature of those barriers. Examples of barriers include, but are not limited to, the following: inaccessible medical equipment in provider offices, inaccessible signage in provider offices (i.e. no Braille writing on signs), inaccessible communication from the Cal MediConnect or providers (i.e. no access to ASL interpreters, no written communication in large print or plain language, or no access to someone who can explain information), inadequate access to appropriate physicians for intellectually disabled

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Enrollees, and incomplete or poor care due to negative attitudes about disability and/or recovery from providers.

Contractor will analyze results of the surveys in order to understand the underlying causes of these barriers to health care access. Contractor will identify issues within its system of care that require improvement to promote access and ADA

3. Other topic areas to be identified through annual guidance by CMS and DHCS in accordance with 42 C.F.R. § 422.152(c) and 422.152(d).

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Appendix E: Addendum to Capitated Financial Alignment Contract

PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS"), ~~and _____~~, the State of California, acting by and through the Department of Health Care Services (DHCS), and <PLAN>, a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract <CONTRACT ID>~~####~~ governing Contractor's operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

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Article I

Voluntary Medicare Prescription Drug Plan

A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the current *Medicare-Medicaid Plan* ~~*2013 Capitated Financial Alignment*~~ *Application*~~, released on March 29, 2012~~ [(hereinafter collectively referred to as "the addendum"). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, DHCS, and CMS.

Article II
Functions to be Performed by Contractor

A. ENROLLMENT

Contractor agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. § 423.30(a) and who have elected to enroll in Contractor's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined

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under 42 C.F.R. § 423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. § 423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. § 423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. § 423.48.

2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the Contract year as provided in 42 C.F.R. § 423.505(o).

3. Contractor agrees to disclose information related to Part D benefits to beneficiaries in the manner and form specified by CMS under §§ 423.128 and 423 Subpart V, consistent with guidance provided in the Marketing Guidance for California Medicare-Medicaid Plans.

~~3. certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Communications and Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.~~

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. Contractor agrees to address Complaints received by CMS against the Contractor as required in 42 C.F.R. § 423.505(b)(22) by:

   (a) Addressing and resolving Complaints in the CMS Complaint tracking system; and

   (b) Displaying a link to the electronic Complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part

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423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO CONTRACTOR

Contractor and CMS and DHCS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, DHCS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. § 422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. § 423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and DHCS (as defined in Appendix I) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and DHCS that meet the requirements of 42 C.F.R. § 423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. § 423.124.

3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. § 423.100), and long-term care

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pharmacies (as defined in 42 C.F.R. § 423.100) according to 42 C.F.R. § 423.505(b)(17).

4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. § 423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. § 423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. § 423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. § 423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

Contractor must provide certifications in accordance with 42 C.F.R. § 423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. Contractor shall submit prescription drug event data in accordance with 42 C.F.R. § 423.329(b)(3).

P. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the

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cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

~~1.~~2. If the source for any prescription drug pricing standard is not publicly available, the Contractor will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of pharmacies.

~~2.~~3. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

~~3.~~4. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the “Final Medicare Part D Reporting Requirements,” a document issued by CMS and subject to modification each program year.

C. CMS AND DHCS LICENSE FOR USE OF CONTRACTOR FORMULARY

Contractor agrees to submit to CMS and DHCS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

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A. Contractor agrees to comply with the confidentiality and Enrollee record accuracy requirements specified in 42 C.F.R. §423.136.

B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2013. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if—

   (a) Contractor has not provided CMS or DHCS with a notice of intention not to renew in accordance with Article VII of this addendum.

2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and DHCS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VI
Nonrenewal of Addendum By Contractor

A. Contractor may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to

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Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article IX
Termination of Addendum by Contractor

A. Contractor may terminate this addendum only in accordance with 42 C.F.R. 423.510.

B. If the addendum is terminated under section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article X
Relationship between Addendum and Capitated Financial Alignment Contract

A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment Contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment Contract to which this document is an addendum.

C. In the event that Contractor's Capitated Financial Alignment Contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, Contractor, DHCS and CMS shall provide notice to Enrollees and the public as described in this Contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

Article XIII

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Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

~~D. CMS AND DHCS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES~~

~~Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and DHCS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and DHCS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.~~

~~E.~~D. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

E. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

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F. Business Continuity: Contractor agrees to develop, maintain, and implement a business continuity plan as required by 42 C.F.R. § 423.505(p).

G. Contractor agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 C.F.R. Part 92, including submitting assurances that the Contractor's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 C.F.R. § 92.4.

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Appendix F: Data Use Attestation

The Contractor shall restrict its use and disclosure of Medicare and Medi-Cal data obtained from CMS and DHCS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and DHCS to administer. The Contractor shall only maintain data obtained from CMS and DHCS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and DHCS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or DHCS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and DHCS.

The Contractor further attests that it shall limit the use of information it obtains from its Medicare-Medicaid Enrollees to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Medicare-Medicaid Enrollees information about non-health related services after obtaining consent. Second, the Contractor may provide information about health-related services without obtaining prior consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Enrollees beyond the scope for which CMS and DHCS have authorized under this agreement. A termination of this data use agreement may result in CMS or DHCS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an Integrated Care Organization (Cal MediConnect). This agreement shall remain in effect as long as the Contractor remains a Cal MediConnect sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or DHCS make available to the general public on their websites.

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Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

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Appendix G: Model File & Use Certification Form

Pursuant to the Contract between the Centers for Medicare & Medicaid Services (CMS), the State of California, acting by and through the Department of Health Care Services (DHCS) and Plan hereafter referred to as the Contractor, governing the operations of the following health plan: _____, the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or DHCS to be misleading or inaccurate or that do not follow established ~~Medicare Communications and Marketing Guidelines,~~ Regulations and the Marketing Guidance for California Medicare-Medicaid Plans~~, and sub-regulatory guidance~~. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. Subpart V, §§422.2260 – 422.227~~46~~ and 42 C.F.R. §422.111 and the Marketing Gudiance for California Medicare-Medicaid Plans.~~for Cal MediConnect and the Medicare Communications and Marketing Guidelines.~~

I agree that CMS or DHCS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and DHCS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor.

Appendix H: Medicare Mark License Agreement

THIS AGREEMENT is made and entered into January 1, 2018

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by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Plan (hereinafter "Licensee"),
with offices located at _____.

CMS Contract ID: _____

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WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning September 1, 2019.

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WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Marketing Guidance for California Medicare-Medicaid Plans~~Medicare Communications and Marketing Guidelines~~. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2022~~19~~, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately.~~Starting December 31, 2019, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract.~~ This agreement shall terminate, without written notice, upon the

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effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

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Appendix I: Service Area

The Service Area outlined below is contingent upon the Contactor meeting all Readiness Review requirements in each county. CMS and DHCS reserve the right to amend Appendix I to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and DHCS.

_____

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Appendix J: Eligible Populations

Enrollment into Cal MediConnect will be available to individuals who meet all of the following criteria:

- Age 21 and older at the time of enrollment;
- Entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, or enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan;
- Eligible for full Medicaid (Medi-Cal), including
    - ~~Individuals enrolled in the Multipurpose Senior Services Program (MSSP).~~
    - Individuals who meet the share of cost provisions described below:
        - ~~Nursing facility residents with a share of cost, and~~
        - ~~MSSP Enrollees with a share of cost, and~~
        - ~~IHSS recipients with a share of cost.~~ .
    - Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act as described below:
        - For those Enrollees who are nursing facility level of care, subacute facility level of care, or intermediate care facility level of care and reside or could reside outside of a hospital or nursing facility, the Department or its designee shall make a Medi-Cal eligibility determination "as if" the beneficiary were in a long-term care facility. Specifically, the spousal impoverishment rule codified section 1924 of the Act will apply to Enrollees. The terms "intermediate care facility level of care" and "nursing facility level of care" and "subacute facility level of care" shall have the same meaning as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- Reside in one of the following Demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
    - Up to 200,000 individuals in Los Angeles may be enrolled in the Demonstration. CMS and the State will monitor the enrollment and stop participation when this enrollment cap is met.
- Individuals residing in San Mateo or Orange county with a diagnosis of end stage renal disease (ESRD) at the time of enrollment.

The following populations will be excluded from enrollment:

- Individuals under age 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through California's regional centers or State developmental centers or intermediate care facilities for the developmentally disabled in Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara counties;
- Individuals with a share of cost that do not meet the requirements outlined

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above;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals living in the following rural zip codes:
    - San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558
    - Los Angeles County - 90704
    - Riverside County - 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, unless they are already enrolled in a separate line of business operated by the Contractor. Individuals enrolled in the Demonstration who are subsequently diagnosed with ESRD, as with all Enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

Individuals that may enroll but may not be passively enrolled include (see section C.2 for a description of Passive Enrollment):

- Individuals residing in the following rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals enrolled in Medicare Advantage in 2014;
- Individuals in one of the following programs may enroll only after they have disenrolled from the program:
    - Individuals enrolled in the following 1915(c) waivers: Nursing Facility/Acute hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and
    - Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

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Appendix K: Disputes

Contractor also agrees to the following:

1. This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues. It shall not be used with respect to any dispute regarding the actuarial soundness of the capitated rate, as provided in paragraph 4.6.2. Filing a dispute will not preclude DHCS and CMS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds twenty-five (25) percent of the capitation payment, amounts of up to twenty-five (25) percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.
2. Disputes Resolution by Negotiation
    a. DHCS, CMS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contract Management Team (CMT) without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.
3. Notification of Dispute
    a. Within fifteen (15) calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the CMT in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.
    b. The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:
        i. That it is a dispute pursuant to this section.
        ii. The date, nature, and circumstances of the conduct which is subject of the dispute.
        iii. The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official or CMS employee involved in or knowledgeable about the conduct.
        iv. The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
        v. The reason the Contractor is disputing the conduct.
        vi. The cost impact to the Contractor directly attributable to the alleged conduct, if any.
        vii. The Contractor's desired remedy.

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c. The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent Appeal.

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

4. CMT or Alternate Dispute Officer's Decision

a. Pursuant to a request by Contractor, the CMT may provide for a dispute to be decided by an alternate dispute officer designated by DHCS and CMS, who is not a member of the CMT and is not directly involved in Medicare or the Medi-Cal Managed Care Program, as appropriate for the issue involved. Any disputes concerning performance of this Contract shall be decided by the CMT or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) calendar days of receipt of a Notification of Dispute, the CMT or the alternate dispute officer, shall either:

i. Find in favor of Contractor, in which case the CMT or alternate dispute officer may:

A. Countermand the earlier conduct which caused Contractor to file a dispute; or

ii. Or,

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

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

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5. Appeal of CMT or Alternate Dispute Officer's Decision

    a. Contractor shall have thirty (30) calendar days following the receipt of the decision to file an Appeal of the decision to the Director and the Medicare Drug & Health Plan Contract Administration Group Director, Center for Medicare. All Appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All Appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An Appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An Appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's Appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely Appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph 7, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Appendix K, Disputes, prior to initiating any other action to enforce this Contract.

6. Contractor Duty to Perform

    a. Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851(d) and proceed diligently with the performance of this Contract and in accordance with the CMT or alternate dispute officer's decision. If pursuant to an Appeal under Paragraph 5, Appeal of CMT or Alternate Dispute Officer's Decision above, the CMT or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph 5. shall be retroactive to the date of the CMT or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. CMS and DHCS shall not pay interest on any amounts paid pursuant to a CMT or alternate dispute officer's decision or any Appeal of such decision, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.

7. Waiver of Claims

    a. If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an Appeal of the CMT or alternate dispute officer's decision, in the manner and within the time specified in this Appendix K, Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

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Appendix L: Additional Medicare Waivers

In addition to the waivers granted for the Cal MediConnect demonstration in the MOU, CMS hereby waives:

L1. Section 1860-D1 of the Social Security Act, as implemented in 42 C.F.R. § 423.38(c)((4)(i), and extend Sections 1851(a), (c), (e), and (g) of the Social Security Act, as implemented in 42 C.F.R. Part 422, Subpart B only insofar as such provisions are inconsistent with allowing dually eligible beneficiaries to change enrollment on a monthly basis.

L2. Section 1851(d) of the Social Security Act and the implementing regulations at 42 C.F.R. § 422, Subpart C, only insofar as such provisions are inconsistent with the network adequacy processes provided under the Demonstration.

L3. No sooner than January 1, 2022, Section 1851(h), Section 1852(c), and Section 1860 D-4 of the Social Security Act and the implementing regulations at 42 C.F.R. 422 and 423, Subparts C and V, only insofar as such provisions are inconsistent with the Marketing Guidance for California Medicare-Medicaid Plans developed for the Demonstration.

L4. Section 1857 (c) and (d) of the Social Security Act and the implementing regulations at 42 C.F.R. §§ 422.506(a)(2)(ii), 422.2267(e)(1), 422.2267(e)(3), 422.2267(e)(10) insofar as such provisions are inconsistent with communicating with CalMediconnect beneficiaries earlier than 90 days until the end of the Demonstration, and tailoring the beneficiary communications to include alternative enrollment options that provide integrated care as well as allowing the affiliated D-SNPs to utilize a customized Annual Notice of Change and Evidence of Coverage for the transition of members from MMPs to D=SNPs.

L5. Section 1851(c) of the Social Security Act and the implementing regulations at 42 C.F.R. § 422.60(g) insofar as such provisions are inconsistent with transitioning CalMediconnect beneficiaries into an affiliated dual special needs plan at the end of the Demonstration.

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<u>Attachment 3:</u> Medicare-Medicaid Plan (MMP) Cal MediConnect (OneCare Connect) Three(3)-Way Contract for 2022 between CMS / DHCS / CalOptima

The 2022 3-Way Contract contains technical changes throughout, as well as changes for the following:

Section/Provision:	Page	Updates to Provision:
Definition of Terms	Pages 3 - 20	• New terms added to define Alternative Format, Community Supports, Cultural Competence, Data Exchange Systems (DEX), Incentive Arrangement, State Plan, Telehealth. • Modifies how certain existing terms are defined, such as Indian Enrollee, Marketing/Outreach & Enrollee Communications, MSSP, Network Provider, Privacy Rules, Threshold Languages.
Removal of the 6-month enrollment moratorium at the end of the demonstration (Section 2.3.1.2)	Page 26	• Removes the reference that limits enrollment into CMC to 6-months prior to the end of the demonstration.
Addition of Community Supports (Section 2.4.4)	Pages 35 - 48	• New set of provisions added to incorporate Community Supports requirements under Cal MediConnect, including: 1. Responsibility for Administration of Community Supports 2. DHCS Pre-Approved Community Supports 3. Community Support Providers 4. Community Support Provider Capacity 5. Identifying Members for Community Supports 6. Authorizing Members for Community Supports and Communication of Authorization Status 7. Referring Members to Community Supports Providers 8. Data System Requirements and Data Sharing 9. Oversight of Community Support Providers 10. Delegation of Community Supports administration to Subcontractors 11. Payment of Community Support Providers 12. DHCS oversight of Community Supports (reporting, monitoring, Encounter data) • Community Supports Quality and Performance Incentive Program
Authorization decision Timeframes (Section 2.11.5)	Pages 91-95	• Adds new provisions to reference the timeframes specific to Part B Drugs.
Dismissal of authorization requests (Section 2.11.5.7.1.)	Pages 95-97	• New set of provisions to incorporate the new Dismissal processes required by CMS Final Rule for Organization Determinations (*also removes the previous provision that references "Withdrawal of Appeal" which is <u>moved</u> to the Appeals section, see below*).
Enrollee Service Telephone Responsiveness (Section 2.12.2.1)	Pages 103-10	• Clarifies provision with additional details on metrics required for disconnect rate for unexpectedly dropped calls, interpreter availability and TTY calls.
Pharmacy Technical Health Call Center (section 2.12.3)	Pages 104-105	• Adds a new provision to define requirements for a toll-free Pharmacy technical help call center.
Enrollee Appeals (Section 2.15, 2.15.1.5, & 2.15.3.6)	Pages 110-116	• Adds new provisions to reference the timeframes specific to Part B Drugs. • Relocates the provision on the Withdrawal of an Appeal to this section.

Section/Provision:	Page	Updates to Provision:
		• Adds new provisions to incorporate the new Dismissal of Appeals processes required by CMS Final Rule.
QI Activities (Section 2.16.4.1.3)	Pages 126-127	• Clarifies the provisions to specify the reporting requirements and its various sources.
Marketing, Outreach and Enrollee Communication (Section 2.17.2)	Page 134	• Clarifies the provision to require member mailings include availability of language assistance services and non-discrimination notice or statement.
MSSP carve-out	Pages 16, 59, 215	• Provisions throughout the contract are updated to make reference to the carve-out of the MSSP benefit, including in the following sections: Definition of Terms / Section 2.6 Long Term Services and Supports / Appendix A: Covered Services / Appendix J: Eligible Populations.
Capitated Rate Structure (Section 4.2.1.1.3)	Page 157	• Adds new provision about how the population will be categorized into 3 risk adjustment population categories for Demonstration Year 8 (i.e. 2022).
Demonstration Transition (Phase Out) (Section 3.3)	Page 153	• Adds new provision about phase-out requirements for CMS and DHCS.
Special Contract Provisions Related to Payment	Page 187-188	• Adds new provision about reimbursement of Network Providers under the Directed Payment Initiative, and complying with the COVID-19 Vaccination Incentive Program.
Medicare Waivers with respect to the end of the CMC demonstration (Appendix L)	Page 247	• New set of provisions added to allow certain flexibilities for particular components of the CMC to D-SNP transition, such as: 1) Network Adequacy processes; 2) Marketing guidance for California MMPs; 3) Communications with CMC members no earlier than 90-days and tailoring communications to include alternative enrollment options that provide integrated care, and utilizing customized ANOCs & EOCs for the transition members; and 4) Transitioning CMC members into an affiliated D-SNP at the end of the Demonstration.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Approve Amendment 3 to the Memorandum of Understanding for the Coordination of Behavioral Health Services with the County of Orange

Contact

Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

Approve Amendment 3 to CalOptima's Memorandum of Understanding (MOU) for the Coordination of Behavioral Health Services with the Orange County Health Care Agency (County) effective June 1, 2022.

a. Revise language in Section XII ("Dispute Resolution"), to comply with the California Department of Health Care Services (DHCS) requirements regarding dispute resolution per APL 21-003.
b. Add subsection IV.H, defining the Enhanced Care Management (ECM) Medi-Cal benefit under the California Advancing and Innovating Medi-Cal program (CalAIM).
c. Replace all references to "HHP" (Health Homes Program) with "ECM" (Enhanced Care Management).

Background and Discussion

Staff requests approval of Amendment 3 to CalOptima's MOU for the Coordination of Behavioral Health Services with the County with a June 1, 2022 effective date. The MOU has been in effect since 2015 and provides guidance and parameters for the coordination of behavioral health services between CalOptima and the County for Medi-Cal members. The agreement was created to support the full spectrum of behavioral health services by leveraging the complementary resources of both organizations. Where CalOptima provides most of the non-specialty behavioral health care services, including mental health screenings, psychological testing, and Outpatient laboratory services, the County's partner organizations provide specialty behavioral health care services, including psychiatric evaluation, crisis intervention, and intensive day treatment.

Prior to this third amendment, the MOU was amended twice to comply with DHCS directives. The first amendment in 2017 was for coordination of Drug Medi-Cal services between CalOptima and the County, and the second amendment was in 2019 for coordination of mental health services with the County. Changes to the MOU reflected in Amendment 3, currently under consideration, will achieve regulatory compliance with DHCS directives and reflect recent operational changes. Below is a summary of changes to the MOU contemplated in Amendment 3:

1. *Section XII Revision*: Per APL 21-013, Managed Care Plans (MCP) and County partners will update processes for clinical and administrative dispute resolution as follows:

I. Non-Urgent Disputes:

a. *"Routine Dispute Resolution"*: The MCP and County are allowed 15 days to resolve the dispute at the local level. If a resolution is not achieved, they have an additional three-

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day period to escalate by submitting a "Request for Resolution" form to DHCS.

II. Urgent Disputes:

b. *"Expedited Dispute Resolution"*: If a member is awaiting a disputed service, and it is determined that the timeframe for Routine Dispute Resolution jeopardizes the member's life, health or ability to attain, maintain, or regain maximum function, CalOptima and the County have one day from the time the dispute is identified to escalate by submitting a "Request for Resolution" form to DHCS.

2. *New Subsection IV.H*: The Health Homes Program ended on January 1, 2022, upon the implementation of the CalAIM program. Accordingly, members receiving HHP services transitioned to ECM services under CalAIM. As such, Amendment 3 adds "Enhanced Care Management" under Section IV, "Definitions," as well as replaces all references to "HHP" throughout the MOU with "ECM."

To ensure members continue to receive timely access to care and ensure the MOU reflects current operational practices, staff requests approval of Amendment 3 to the MOU for Coordination of Behavioral Health Services, effective June 1, 2022.

Fiscal Impact

The recommended action to amend the CalOptima's MOU for Behavioral Health Services with the County has no additional fiscal impact to CalOptima.

Rationale for Recommendation

Amendment 3 will ensure that members receive timely access to care and reflect the most current operational practices.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Amendment 3 [Proposed] to the Memorandum of Understanding for the Coordination of Behavioral Health Services.
3. APL 21-003

Board Actions

N/A

/s/ Michael Hunn *04/28/2022*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Healthcare Agency	405 W. 5th St.	Santa Ana	CA	92701

AMENDMENT 3
TO THE
MEMORANDUM OF UNDERSTANDING
FOR THE COORDINATION OF BEHAVIORAL HEALTH SERVICES

THIS AMENDMENT 3 to the Memorandum of Understanding for the Coordination of Behavioral Health Services is entered into by and between the Orange County Health Authority, dba CalOptima, a public agency ("CalOptima"), and the County of Orange, through its division the Orange County Health Care Agency ("HCA"), a political subdivision of the State of California, and shall become effective on the first day of the first month following execution of this Amendment 3 by both Parties (the "Amendment Effective Date"), with respect to the following facts:

RECITALS

A. HCA provides a full spectrum of specialty mental health services for the evaluation, diagnosis, treatment, and follow-up of seriously and persistently mentally ill adults and seriously emotionally disturbed children and youth who meet medical necessity criteria as defined by the Title 9 of the C.C.R., and a continuum of care for individuals with substance use disorders who meet medical necessity criteria as defined in 22 C.C.R. Section 51303.

B. CalOptima is a local public agency which, by statute, has the responsibility of operating a County Organized Health System ("COHS") for Orange County, California. CalOptima coordinates the provision of health care services, including non-specialty mental health services, to Orange County Medi-Cal beneficiaries using managed care principals.

C. CalOptima and HCA entered into the Memorandum of Understanding for the Coordination of Mental Health Services on February 1, 2015 ("MOU") whereby CalOptima and HCA described the responsibilities of both Parties for the coordination of mental health services to ensure access to necessary, appropriate, and timely mental health services to CalOptima Members; Amendment 1, effective November 1, 2017, which added provisions related to the coordination of Drug Medi-Cal services and changed the title of this MOU to Memorandum of Understanding for the Coordination of Behavioral Health Services; and Amendment 2, effective October 1, 2019, which updated the MOU to describe responsibilities of CalOptima and HCA specific to Members with mental health conditions who are enrolled in the Health Homes Program, to comply with DHCS requirements specified in All Plan Letter ("APL") 18-015, and to revise HCA's name on the MOU.

D. The purpose of this Amendment 3 is to update the MOU in order to comply with DHCS requirements described in APL 21-013 and Behavioral Health Information Notice No. 21-034 related to the resolution of service delivery disputes between CalOptima and HCA. This Amendment 3 also updates references to CalOptima's Health Homes Program ("HHP"), which transitioned to Enhanced Care Management ("ECM") as of January 1, 2022.

E. CalOptima and HCA now desire to amend the MOU on the terms and conditions set forth below.

NOW, THEREFORE, the Parties agree as follows:

1. The following new Subsection IV.H of the MOU shall be added to the end Section IV "Definitions" of the MOU:

   "H. "Enhanced Care Management" or "ECM" means 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, high-touch, and person-centered. ECM is a Medi-Cal benefit."

2. Any reference to "HHP" in the MOU shall be deleted and replaced with "ECM".

3. Section XII "Dispute Resolution" of the MOU shall be deleted in its entirety and replaced with the following new Section XII "Dispute Resolution" of the MOU:

   "XII. DISPUTE RESOLUTION

   A. Routine Disputes.

   CalOptima and HCA shall facilitate timely resolution of clinical and administrative disputes within fifteen (15) business days of identifying the dispute, including differences of opinion about whether a Member is eligible for mental health services under this MOU, or whether HCA should provide mental health services under this MOU. The review process shall: (1) not result in delays in Member access to medically necessary services, including specialty mental health services and prescription drugs under this MOU while the decision from the formal dispute resolution process is pending; and (2) follow rules set forth by the State for determination of financial responsibility for services provided to a Member during the review process. CalOptima and HCA agree to follow the resolution of dispute process in accordance Title 9, C.C.R., Sections 1810.370, 1850.505(d), 1850.525, and 1850.530.

   When a service delivery dispute between CalOptima and HCA cannot be resolved at the local level within the fifteen (15) business day timeframe, CalOptima and/or HCA must submit a written Request for Resolution to DHCS within three (3) business days after failure to resolve the dispute ("Initiating Party"). If CalOptima submits the request to DHCS, it must be signed by CalOptima's Chief Executive Officer (CEO) or the CEO's designee. The Initiating Party's Request for Resolution must be submitted via secure email to MCQMD@dhcs.ca.gov and include:

   1. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the Member by either CalOptima or HCA and the expected rate of payment for each type of service;

   2. A history of attempts to resolve the issue;

   3. Justification for the desired remedy; and

   4. Any additional documentation relevant to resolving the issue.

Upon receipt of a Request for Resolution, DHCS will notify the other party within three (3) business days via secure email ("Notification"). The other party shall submit a response statement to DHCS within three (3) business days from receipt of the Notification and that response shall include any relevant documents to support its position. If the other party fails to respond, DHCS will render a decision on the disputed issue(s) based solely on the documentation filed by the Initiating Party.

If the Request for Resolution to DHCS is related to a rate of payment, the requested rate of the prevailing party shall be deemed correct unless the other party disputes the rate of payment in its response. If the other party fails to respond, DHCS will render a decision on the disputed issue(s) based solely on the documentation filed by the Initiating Party.

DHCS will communicate the final decision via secured email to CalOptima and HCA within twenty (20) business days from the third (3rd) business day after the Notification date. DHCS's decision will state the reasons for the decision, the determination of rates of payment (if applicable), and any required actions that CalOptima and/or HCA must make to implement the decision. Any such required action must be taken no later than the next business day following the date of the DHCS' notice of the final decision.

B. Expedited Disputes.

Either party may seek an expedited dispute resolution if the Member has not received a disputed service(s) and either party determines that the routine dispute resolution process timeframe would result in serious injury to the Member's life, health, or ability to attain, maintain, or regain maximum function.

CalOptima and HCA will have one (1) business day after identification of the dispute to attempt to resolve the dispute at the local level. Both parties will separately submit a Request for Resolution to DHCS via secure email to MCQMD@dhcs.ca.gov within one (1) business day if they fail to resolve the dispute and include:

1. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the Member by either CalOptima or HCA and the expected rate of payment for each type of service;

2. A history of attempts to resolve the issue;

3. Justification for the desired remedy;

4. An affirmation of the stated jeopardy to the Member; and

5. Any additional documentation relevant to resolving the issue.

If either party fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation that was submitted to DHCS. DHCS will communicate the final decision no later than one (1) business day following DHCS's receipt of the Request for Resolution.

C. Financial Liability.

If DHCS' decision includes a finding that the unsuccessful party is financially liable to the other party for services, the parties shall comply with the requirements in Title 9, California Code of Regulations (CCR), section 1850.530. If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

D. Nothing in this Section XII will preclude a Member from utilizing CalOptima or HCA's problem resolution process for Members or any similar process, or to request a fair hearing."

4. Section IX "Dispute Resolution" of Addendum I "Drug Medi-Cal" shall be deleted in its entirety and replaced with the following new Section IX "Dispute Resolution" of Addendum I "Drug Medi-Cal":

"IX. DISPUTE RESOLUTION

CalOptima and HCA shall facilitate timely resolution of clinical and administrative disputes, including differences of opinion about whether a Member is eligible for SUD services or whether HCA should provide SUD services. The review process shall not result in delays in Member access to SUD services while the decision from the formal dispute resolution process is pending. CalOptima and HCA agree to follow the routine and expedited resolution of dispute processes described in Section XII of this MOU."

5. MOU REMAINS IN FULL FORCE AND EFFECT - Except where this Amendment 3 conflicts with and supersedes the MOU, all other conditions contained in the MOU as amended shall continue in full force and effect. This Amendment 3 may be executed in multiple counterparts, and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment 3 shall have the same meanings ascribed to them in the MOU. After the Amendment Effective Date of this Amendment 3, any reference to the MOU shall mean the MOU as amended and supplemented by this Amendment 3.

IN WITNESS WHEREOF, the Parties have executed this Amendment 3.

FOR HCA	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
Veronica A. Kelley	Michael Hunn
PRINT NAME	PRINT NAME
Chief Mental Health Recovery Services	Chief Executive Officer
TITLE	TITLE
_____	_____
DATE	DATE

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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 4, 2021

ALL PLAN LETTER 21-013
SUPERSEDES ALL PLAN LETTER 15-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: DISPUTE RESOLUTION PROCESS BETWEEN MENTAL HEALTH PLANS AND MEDI-CAL MANAGED CARE HEALTH PLANS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on how to submit a service delivery dispute to the Department of Health Care Services (DHCS) when the dispute cannot be resolved at the local level with a Mental Health Plan (MHP). Guidance to MHPs is provided in Behavioral Health Information Notice (BHIN) No: 21-034.[1]

BACKGROUND:

MCPs are contractually required to provide and cover all medically necessary services for members, with the exception of those services that are carved out of the MCP's contract. However, even for carved-out services, MCPs remain contractually responsible for providing Comprehensive Case Management, including coordination of care, to ensure the provision of all medically necessary services, whether those services are delivered within or outside of the MCP's provider network. Comprehensive case management for medically necessary services, including both basic and complex case management, is described in MCP contracts.[2]

POLICY:

MCPs must enter into a Memorandum of Understanding (MOU) with the MHP in each of the counties where the MCP operates.[3] The MOU must include a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services (SMHS) and prescription drugs, while the dispute is being resolved.[4] If an MCP and MHP have a dispute that they are unable to resolve regarding the obligations of the

[1] 2021 BHINs are searchable at https://www.dhcs.ca.gov/formsandpubs/Pages/2021-MHSUDS-BH-Information-Notices.aspx.
[2] Exhibit A, Attachment 11, Case Management and Coordination of Care. MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[3] Exhibit A, Attachment 12, Local Health Department Coordination.
[4] Title 9, CCR, section 1810.370.

MCP or MHP under their respective contracts with DHCS, state laws and/or the MCP - MHP MOU, the parties are required to submit the dispute to the state for resolution as described below. DHCS encourages both MCPs and MHPs to attempt to resolve all disputes collegially, effectively, and at the local level before submitting the dispute to the state for resolution. The local resolution policy should be exhausted within the below prescribed timeframes before filing the dispute with the state.

PROVISION OF SERVICES DURING DISPUTE RESOLUTION PROCESS

State law requires that the provision of medically necessary services must not be delayed during the pendency of a dispute between an MHP and MCP and sets forth rules for determining financial responsibility for services provided to a member during that period.[5] In addition, MCPs are contractually responsible for the provision of case management and care coordination for all medically necessary services a member needs, including those services that are the subject of a dispute between an MCP and MHP. The MCP is responsible for working with MHPs in order to ensure that there is no duplication of SMHS, for which MHPs also provide case management.

ROUTINE DISPUTE RESOLUTION PROCESS:

Regardless of MOU status, MCPs and MHPs must complete the plan level dispute resolution process within 15 business days of identifying the dispute. Within three business days after a failure to resolve the dispute during that timeframe, either the MHP or the MCP must submit a written “Request for Resolution” to DHCS. If the MCP submits the Request for Resoution it must be signed by the MCP’s Chief Executive Officer (CEO) or the CEO’s designee. The Request for Resolution must include:

1. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the member by either the MCP or the MHP and the expected rate of payment for each type of service;
2. A history of the attempts to resolve the issue(s) with the MHP;
3. Justification for the MCP’s desired remedy; and
4. Any additional documentation that the MCP deems relevant to resolve the disputed issue(s), if applicable.

The Request for Resolution must be submitted via secure email to MCQMD@dhcs.ca.gov.

Within three business days of receipt of a Request for Resolution from an MCP, DHCS will forward a copy of the Request for Resolution to the Director of the affiliated MHP via secure email (“Notification”). The MHP will have three business days from the receipt of

[5] Title 9, CCR, section 1850.525.

Notification to submit a response to the MCP's Request for Resolution and to provide any relevant documents to support the MHP's position. If the MHP fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by the MCP. Conversely, if the MHP submits a Request for Resolution to DHCS, DHCS will forward a copy of the Request for Resolution to the affiliated MCP, within three business days of receipt. The MCP will have three business days to respond and provide relevant documents.

If an MHP requests a rate of payment in its Request for Resolution, and the MHP prevails, the requested rate shall be deemed correct, unless the MCP disputes the rate of payment in its response. If the MCP fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by the MHP. Conversely, if an MCP requests a rate of payment in its Request for Resolution, and the MCP prevails, the requested rate shall be deemed correct, unless the MHP disputes the rate of payment in its response. If the MHP fails to respond, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by the MCP.

At its discretion, DHCS may allow representatives of the MCP and MHP the opportunity to present oral arguments.

The Managed Care Quality and Monitoring Division and the Medi-Cal Behavioral Health Division will make a joint recommendation to DHCS' Director, or the Director's designee, based on their review of the submitted documentation; the applicable statutory, regulatory, and contractual obligations of the MCP and the MHP; and any oral arguments presented.

Within 20 business days from the third business day after the Notification date, DHCS will communicate the final decision via secure email to the MCP's CEO (or the CEO's designee, if the designee submitted the Request for Resolution) and the MHP's Director (or the Director's designee, if the designee submitted the Request for Resolution). DHCS' decision will state the reasons for the decision, the determination of rates of payment (if the rates of payment were disputed), and any actions the MCP and MHP are required to take to implement the decision.[6] Any such action required from either the MCP or the MHP must be taken no later than the next business day following the date of the decision.

EXPEDITED DISPUTE RESOLUTION PROCESS

The MCP and MHP may seek to enter into an expedited dispute resolution process if a member has not received a disputed service(s) and the MCP and/or MHP determine

[6] Title 9, CCR, sections 1850.530(c) and 1850.505(d)(1)

that the Routine Dispute Resolution Process timeframe would result in serious jeopardy to the member's life, health, or ability to attain, maintain, or regain maximum function.

Under this expedited process, the MCP and MHP will have one business day after identification of a dispute to attempt to resolve the dispute at the plan level. Within one business day after a failure to resolve the dispute in that timeframe, both plans will separately submit a Request for Resolution to DHCS, as set out above, including an affirmation of the stated jeopardy to the member.

If the MHP fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by the MCP. Conversely, if the If the MCP fails to submit a Request for Resolution, DHCS will render a decision on the disputed issue(s) based on the documentation submitted by the MHP.

DHCS will provide a decision no later than one business day following DHCS' receipt of Request for Resolution from both parties and affirmation of the stated jeopardy to the member.

FINANCIAL LIABILITY

If DHCS' decision includes a finding that the unsuccessful party is financially liable to the other party for services, the MCP or MHP is required to comply with the requirements in Title 9, California Code of Regulations (CCR), section 1850.530.[7] If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract

[7] CCRs are searchable at: https://govt.westlaw.com/calregs/Search/Index.

requirements, and other DHCS guidance, including APLs and Policy Letters.[8] 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

[8] For more information on subcontractors and network providers, including the definition and requirements applicable, see APL 19-001 and any subsequent APLs on this topic. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

CalOptima Board Action Agenda Referral

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Authorize Extension and Amendment of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith LLC

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's contract with Edelstein Gilbert Robson & Smith LLC (EGRS) for state legislative advocacy services as follows:

a. Exercise the fourth and final one-year option to extend the contract term, according to the provisions of the current contract, from July 1, 2022, through June 30, 2023; and
b. Incorporate CalOptima's payment of a nominal filing fee for state lobbying disclosures.

Background

CalOptima retains representation in Sacramento to assist with tracking and advocacy on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, and applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a request for proposal (RFP) for state legislative advocacy services was issued in March 2018, and proposals were received from two advocacy firms. Subsequently, evaluation and interviews were conducted by CalOptima staff, external subject matter experts, and a Board of Directors (Board) ad hoc committee, which recommended EGRS. On June 7, 2018, the Board authorized the CEO to contract with EGRS for a one-year term commencing on July 1, 2018, with four one-year extension options, each exercisable at CalOptima's sole discretion. On May 6, 2021, the Board exercised the third one-year option to extend the current contract term through June 30, 2022.

Discussion

EGRS has substantial knowledge and experience in health care issues important to CalOptima. In the past year, EGRS has engaged with issues, including but not limited to the California Advancing and Innovating Medi-Cal initiative, Program of All-Inclusive Care for the Elderly, and County Organized Health System.

As proposed, the recommended action authorizes extending the EGRS contract for a final one-year term (i.e., the fourth of four one-year extension options included in the contract). The EGRS

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contract fee is $100,000 annually, or $8,333.33 per month, which includes phone, fax, in-office copying, regular postage and printing. In addition, staff recommends amending the contract to incorporate CalOptima's payment of a separate pass-through fee of $600 annually, or $150 per quarter, for an EGRS subcontractor to file lobbying disclosures with the California Secretary of State. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

Consistent with CalOptima's practice, staff will monitor the performance of EGRS to ensure that the deliverables and components outlined in the contract are being achieved. Deliverables include but are not limited to providing written and verbal reports to staff, monitoring legislation, coordinating meetings with state officials and implementing advocacy efforts as directed by the Board and staff. When appropriate, occasional in-person updates will be provided at Board meetings.

Fiscal Impact

Management will include expenses related to the EGRS contract extension from July 1, 2022, through June 30, 2023, for state legislative advocacy services in the CalOptima Fiscal Year 2022–23 Operating Budget.

Rationale for Recommendation

State legislative advocacy efforts continue to be a priority for CalOptima given the level of activity on health care issues in Sacramento. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. EGRS Contract No. 18-10701 (As Currently Amended)
3. Proposed EGRS Contract Amendment No. 4

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Edelstein Gilbert Robson & Smith LLC	1127 11th Street, Suite 1030	Sacramento	CA	95814

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CONTRACT NO. 18-10701

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, dba CALOPTIMA and

EDELSTEIN, GILBERT, ROBSON & SMITH, L.L.C.

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 Edelstein, Gilbert, Robson & Smith, L.L.C. a Limited Liability Company (LLC), 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 State Legislative Advocacy Services for CalOptima, 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") 18-039, if applicable, inclusive of any revisions, amendments and addenda thereto, and (iii) CONTRACTOR's proposal dated April 13, 2018. 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 April 13, 2018.

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. 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.

Name	Function/Title
Don Gilbert	Partner
Trent Smith	Partner

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 $1,200,000 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 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 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, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 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.

3.2.8 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.

3.2.9 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. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

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 whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. 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. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

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 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 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 warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 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.

13.6 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 no later than 07/01/2018 and shall continue in full force and effect through 06/30/2019, ("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 four (4) 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 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 premises, physical facilities and equipment, 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.

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 letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables 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.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials 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 property and materials, including the 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 any item furnished under this Contract, 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. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

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 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. 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.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. 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.

28. 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.

29. 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.

30. 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.

31. 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:
Edelstein, Gilbert, Robson & Smith, LLC	CalOptima
1127 11th Street, Suite 1030	505 City Parkway West
Sacramento, CA 95814	Orange, CA 92868
Attention: Trent Smith	Attention: Mark Finch, C.P.M., CPPO, CPSM
Partner	Purchasing Manager

32. 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.

33. Unavoidable Delays.

33.1 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.

33.2 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.

33.3 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.

34. 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.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such arbitration, action or proceeding.

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.

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 41.2.2 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 42.3of 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 42.3 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 42.2.2herein. 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 42.2.1of 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 42.2.1of 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.

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.

[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. 18-10701 on the day and year last shown below.

[VENDOR NAME] Edelstein Gilbert Robinson-Smith, LLC	CalOptima
By:	By:
Print Name: Treat E. Smith	Print Name: Greg Hamblin
Title: Manager	Title: CFO & Treasurer
Date: August 16, 2018	Date: 9-4-18

By:
Print Name: Donald B. Gilbert
Title: Manager
Date: August 16, 2018

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

Exhibit A

A. SCOPE OF WORK

CONSULTANT shall represent CalOptima's day-to-day interests in Sacramento with the California State Legislature, the Administration, and other relevant departments and agencies, offering legislative monitoring and other necessary advocacy services to CalOptima.

B. REPORTING RELATIONSHIP

The Chief Executive Officer; Executive Director, Public Policy and Public Affairs; and Director, Government Affairs (Business Owners) and/or their designee(s) will be the primary contacts and will direct the work of the CONSULTANT. All work in excess of that expressed in this Scope of Work shall be approved by the Business Owners in conjunction with the Purchasing department. This additional work will be evidenced in an amendment to this Contract prior to the work commencing.

C. OBJECTIVES/DELIVERABLES

CONSULTANT shall:

1. Maintain regular contact with members of the California Legislature, committee staff, and other state departments, agencies, boards and commissions, to identify impending changes in laws, regulations and funding priorities that relate to CalOptima.

2. Provide a written monthly report that shall accompany the invoice to describe the nature and extent of the services or actions taken on behalf of CalOptima as well as report on issues in Sacramento that may impact CalOptima's programs and funding. Written reports should also include general information regarding the health care industry in California that may have a direct or indirect impact on CalOptima.

3. Notify CalOptima of anticipated, introduced or amended state legislation, and regulations that could impact CalOptima. These activities include but are not limited to:

   Providing bill numbers and a brief summary of introduced or amended state legislation;

   Providing copies of legislation and committee analysis; and

   Providing information related to legislative hearings.

4. Advocate for CalOptima's programs and positions on proposed legislation, proposed regulations, and funding priorities as directed. These activities shall include by are not limited to:

Informing CalOptima of upcoming legislative proposals, budget forecasts and relevant policy issues;

Assisting in securing authors and drafting language for sponsored bills;

Assisting in drafting amendments to legislation;

Testifying on behalf of CalOptima at legislative hearings; and

Monitoring, reviewing and providing ongoing advice regarding the impact of the State budget on CalOptima's programs
Drafting letters of support/opposition

5. Provide copies of all written correspondence, testimony and position papers given on behalf of CalOptima, as well as provide copies of the State Budget and any related documents to the Business Owners.

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 monthly basis. 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. 18-10701 provide a 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 One Hundred Thousand Dollars ($100,000), for the initial contract term 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.

E. CONTRACTOR's billable rate shall be Eight Thousand Three Hundred Thirty-Three Dollars and Thirty-Three Cents $8,333.33 per month. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR shall also invoice CalOptima on aa as-needed basis for travel-related expenses to CalOptima. All 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.

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, Edelstein, Gilbert, Robson & Smith, 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: _____ Date: August 16, 2018

Print Name: Trent E. Smith

Title: Manager

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.

Edelstein Gilbert Robson + Smith, LLC
Name of Contractor

Treat E. Smith
Printed Name of Person Signing for Contractor

Contract No. 18-10701
Contract/Grant Number

Signature of Person Signing for Contractor

August 16, 2018
Date

Manager
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 I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Edelstein Gilbert Robson & Smith, LLC

Business Entity Type: Limited Liability Corporation
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 1127 11th St, Ste. 1030

City: Sacramento State: CA Zip: 95814

Business Phone: 916-443-6400 Email: : trent@egrslobby.com

President: _____ Contact Person: Trent E. Smith

Person(s) Signing Contract & Title: : Trent E. Smith, Manager

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
Donald B. Gilbert	Manager 40.5 %
Michael R. Robson	Manager 31 %
Trent E. Smith	Manager 28.5 %

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.

_____ August 16, 2018
Authorized Signature Date

Trent E. Smith, Manager
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

AMENDMENT NO. 1 TO CONTRACT NO. 18-10701

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as of July 1, 2019, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. The Parties desire to amend the Contract to take advantage of the first (1st) of the four (4) extended terms available per Section 15 Of the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Amend Section 15 of the Contract to extend the termination date to June 30, 2020.

2. All other terms and conditions of the Contract remain unchanged.

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

EDELSTEIN, GILBERT, ROBSON & SMITH

By: _____

Print Name: Trent Smith

Its: Partner

Date: 8/1/2019

CALOPTIMA

By: _____

Print Name: Michael Schrader

Its: Chief Executive Officer

Date: 8-2-19

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AMENDMENT NO. 2 TO CONTRACT NO. 18-10701

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
(CalOptima)

AND

EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as of July 1, 2020, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services. Amendment No. 1 was entered into as of July 1, 2019.

B. The Parties desire to amend the Contract to take advantage of the second (2nd) of the four (4) extended terms available per Section 15 Of the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Amend Section 15 of the Contract to extend the termination date to June 30, 2021.

2. All other terms and conditions of the Contract remain unchanged.

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

EDELSTEIN, GILBERT, ROBSON & SMITH

By: _____

Print Name: Trent Smith

Its: Partner, EGRS

Date: 8/10/2020

CALOPTIMA

By : DocuSigned by: Richard Sanchez 234AD421BDEC4D9...

Print Name: Richard Sanchez

Its: Interim Chief Executive Officer

Date: 08/24/2020

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AMENDMENT NO. 3 TO CONTRACT NO. 18-10701
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA
CALOPTIMA
(CalOptima)
AND
EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 3 TO THIS CONTRACT is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. Amendment No. 1 was entered into as of July 1, 2019, and Amendment No. 2 was entered into as of July 1, 2020.

C. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both parties.

D. The Parties now desire to extend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Pursuant to Section 15 of the Contract, the third of four Extended Terms is hereby executed to extend the Contract Term to June 30, 2022.

2. **No Other Changes.** This Amendment No. 3 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 3 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[Signature to follow on next page]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 3 to Contract 18-10701 on the day and year last shown below.

EDELSTEIN, GILBERT, ROBSON & SMITH

Signature: _____

Print Name: Trent Smith

Title: Partner/Manager

Date: 4/8/2021

Signature: _____

Print Name: _____

Title: _____

Date: _____

CALOPTIMA

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Print Name : Nancy Huang

Title: CFO, CalOptima

Date: 05/17/2021

Signature: DocuSigned by: Richard Sanchez 234AD421BDEC4D9...

Print Name : Richard Sanchez

Title: CEO, CalOptima

Date: 05/17/2021

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AMENDMENT NO. 4 TO CONTRACT NO. 18-10701
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA
CALOPTIMA
(CalOptima)
AND
EDELSTEIN, GILBERT, ROBSON & SMITH
(CONTRACTOR)

AMENDMENT NO. 4 TO THIS CONTRACT is entered into as of the date last signed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 18-10701 on September 4, 2018 for State Legislative Advocacy Services.

B. Amendment No. 1 was entered into as of July 1, 2019, Amendment No. 2 was entered into as of July 1, 2020, and Amendment No. 3 was entered into on 5/17/2021.

C. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both parties.

D. The Parties now desire to extend the Contract, and to add an additional service.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Pursuant to Section 15 of the Contract, the fourth of four Extended Terms is hereby executed to extend the Contract Term to June 30, 2023.

2. CONTRACTOR shall pass-through fees for quarterly preparation and submission of State Lobbying Disclosures, at a quarterly cost of One Hundred Fifty Dollars ($150.00), totaling an annual cost of Six Hundred Dollars ($600.00).

3. **No Other Changes**. This Amendment No. 4 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 4 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[Signature to follow on next page]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 4 to Contract 18-10701 on the day and year last shown below.

EDELSTEIN, GILBERT, ROBSON & SMITH

Signature: _____

Print Name: Trent Smith

Title: Partner

Date: 4/12/2022

Signature: _____

Print Name: _____

Title: _____

Date: _____

CALOPTIMA

Signature: _____

Print Name : _____

Title: _____

Date: _____

Signature: _____

Print Name : _____

Title: _____

Date: _____

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
10. Authorize the Chief Executive Officer to Amend the Contract with Kennaday Leavitt PC

Contact
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action
Authorize the Chief Executive Officer (CEO) to amend the contract with Kennaday Leavitt PC, to revise the scope of work and payment terms.

Background and Discussion
On November 4, 2021, the CalOptima Board of Directors authorized the CEO to execute a contract with Kennaday Leavitt PC to serve as general counsel. The term of the contract was November 4, 2021, through October 31, 2022, with two (2) additional one-year extension options, each exercisable at CalOptima's sole discretion. The Board also authorized unbudgeted expenditures up to $1.05 million from reserves to fund the contract.

Staff requests the Board's approval to amend the contract with Kennaday Leavitt. Substantive changes to the scope of work will include the following:

- Specify that Kennaday Leavitt will report to the CEO in addition to the Board;
- Specify that Kennaday Leavitt's regulatory duties include securing and maintaining required licenses or authorities to operate the plan, any products or programs;
- Add legal defense duties; and
- Remove references to an internal legal team.

With the addition of legal defense duties, staff requests approval to amend the payment terms from a monthly retainer of $70,000 and $500/hour for legal defense, to a blended hourly rate of $475/hour for attorneys and $150/hour for paralegals. Additional payment term amendments include increasing the travel expense maximum from $2,000 to $5,000.

The above amendments will align Kennaday Leavitt PC's services to the current CalOptima operating model. Staff request the Board to authorize the CEO to amend the contract as described above and implement the amendment upon execution.

Fiscal Impact
There is no additional fiscal impact for Fiscal Year (FY) 2021-22 beyond the funding approved by the Board on November 4, 2021. The revised estimated annual cost is approximately $1.3 million, which is $250,000 higher than the previous estimate. Staff will include the increased cost in the proposed FY 2022-23 Operating Budget.

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Rationale for Recommendation

The requested amendments to the Kennaday Leavitt PC contract will align legal services to the current CalOptima operating model.

Concurrence

N/A

Attachments

None

/s/ Michael Hunn *04/28/2022*

Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Ratification of Expenditures Related to Health Insurance Portability and Accountability Act (HIPAA) Security; Authorize Contract with Vendors Providing Security Software Services

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
David O'Brien, Director, Information Technology Services, (714) 246-1269

Recommended Actions

1. Ratify contract for CalOptima for Crowdstrike Falcon Complete security software solution.
2. Ratify the use of Tevora Business Solutions as the software reseller for this solution.
3. Ratify unbudgeted expenditures in an amount up to $371,488 from existing reserves to fund the contract for the security software solution.

Background

Traditionally, healthcare has been specifically targeted by threat actors for ransomware attacks, and due to the pandemic, these threats have increased. Many threat actors understood that healthcare organizations cannot afford a business disruption and would likely pay the ransom, if attacked. As a result, this translated to more attacks against healthcare organizations and further increased the likelihood of additional ransomware incidents. Recently, Partnership Health Plan announced it was breached with a ransomware attack that severely impacted their ability to service members for more than two weeks (affecting more than 860K members and compromised 400GB of data off their servers).

Discussion

Security solutions are varied, and few provide the level of protection that not only monitors for threats but also prevents them from happening. Crowdstrike Falcon Complete is both a 24/7 Security Operations Center (SOC) and acts against threats based on behavior and detection. Unlike a traditional SOC, it does not identify a threat "after" an issue occurs but leverages artificial intelligence (AI) and machine learning (ML) to address the attack *before* a threat can infiltrate an environment. This is known as managed detection and response.

Crowdstrike also works across endpoints (end user systems) and cloud and user identities to protect on or off the internal CalOptima network. This solution also functions under the premise of global threat intelligence (GTI). This means if a threat is detected in another organization, CrowdStrike leverages that information for all customers to protect them all.

CrowdStrike also offers a breach prevention warranty, which is an additional protection in the event an issue somehow bypasses its controls. This additional measure allows for cyber-insurance cost reduction as CrowdStrike is confident its solution will protect against threats either known or unknown and provides protection against ransomware behavior.

The risks that face healthcare organizations world-wide also exist here at CalOptima. There is a need for a comprehensive and proven solution that can augment our internal capabilities to provide

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comprehensive cyber security protection. Due to the urgency of these risks, Crowdstrike Falcon Complete also has the ability for rapid deployment, leading to a faster, and more comprehensive implementation (providing us the opportunity to address these risks sooner).

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to $371,488 from existing reserves will fund this action.

Rationale for Recommendation

CalOptima staff recommends ratification of the Crowdstrike Falcon Complete security software solution platform, with Tevora Business Solutions as the reseller. Crowdstrike Falcon Complete is a comprehensive solution to address multiple areas in CalOptima's security posture that are lacking. While these threats can never be 100 percent guaranteed from occurring, this solution positions CalOptima extremely well to identify, protect, and prevent issues from occurring and within HIPAA regulations provides both "due care" and "due diligence" in protecting CalOptima's members and PHI. Just announced on April 1, 2022, *CrowdStrike was the only vendor to demonstrate native and unified Zero Trust and identity protection capabilities in its platform in the MITRE Engenuity ATT&CK® Enterprise Evaluations. CrowdStrike achieved 100% prevention with comprehensive visibility and actionable alerts.* This solution will provide CalOptima with near immediate visibility and protection against threats that would internally take CalOptima at least a year to implement.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Tevora Business Solutions, Inc	17875 Von Karman Ave, Ste. 100	Irvine	CA	92614
Crowdstrike, Inc	150 Mathilda Place, Ste. 300	Sunnyvale	CA	94086

CalOptima Board Action Agenda Referral

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Authorize Extension of Terms for Members of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

The CalOptima OneCare Connect Member Advisory Committee (OCC MAC) recommends the Board:

1. Extend the terms of the following individuals through December 31, 2022:
    a. Gio Corzo as the Community-Based Adult Services (CBAS) Representative;
    b. Meredith Chillemi as the Long-Term Care Representative;
    c. Keiko Gamez as the Member/Authorized Family Member Representative; and
    d. Patty Mouton as the Seniors Representative.

2. Extend the terms of the current Chair and Vice Chair through December 31, 2022:
    a. Patty Mouton, Chair; and
    b. Keiko Gamez, Vice Chair.

Background/Discussion

The CalOptima Board of Directors welcomes community stakeholder involvement and benefits from their input in the form of advisory committees. The Centers for Medicare & Medicaid Services (CMS) and the State of California Department of Health Care Services (DHCS) established requirements for the implementation of the Cal MediConnect program, including a requirement for the establishment of a Cal MediConnect Member Advisory Committee. The CalOptima Board of Directors established the OCC MAC by resolution on February 5, 2015, to provide input and recommendations to the CalOptima Board relative to the OCC program – the Cal MediConnect program administered by CalOptima.

OCC MAC voting members serve two-year terms with no limit on the number of terms a representative may serve. The four seats due to expire on June 30, 2022, include the Community-Based Adult Services (CBAS) Representative, Long-Term Care Representative, one OCC Member/Family Member Representative, and Seniors Representative.

With OneCare Connect sunsetting on December 31, 2022, the committee would benefit from the extension of the expiring terms. The committee will hold three meetings between July 1, 2022, and December 31, 2022, and extending the terms of these representatives allows for the committee to achieve a quorum at these meetings.

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At their April 21, 2022 meeting, OCC MAC members voted to accept the recommended extension for OCC MAC members whose terms end June 30, 2022, and forward this recommendation to the CalOptima Board of Directors for consideration.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
With only three meetings left for the committee, it is not feasible to undertake a recruitment for the seats whose terms will expire on June 30, 2022. Extending the terms of the current incumbents for an additional six months until the conclusion of the OCC program provides uninterrupted representation of the specified seats and is the recommendation of the committee.

Concurrence
OneCare Connect Member Advisory Committee
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn — *04/28/2022*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

13. Receive and File the Annual 2021 Utilization Management Program Evaluation and Approve 2022 Utilization Management Program Description

Contacts

Richard Pitts, Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

1. Receive and file 2021 CalOptima Utilization Management (UM) Program Evaluation; and
2. Approve the 2022 Utilization Management (UM) Program Description.

Background/Discussion

CalOptima evaluates the effectiveness of the UM Program annually. In the evaluation, CalOptima reviews the following:

- Program structure;
- Responsibility for the UM program;
- New initiatives/programs; and
- Program scope and processes used to determine benefit coverage and medical necessity.

Based upon the evaluation, the program description is revised and updated for the following year to address previous year opportunities.

The 2021 UM Evaluation and 2022 UM Program Description were reviewed by the Utilization Management Committee (UMC) and approved on April 15, 2022.

2021 UM Program Evaluation:

The annual look back period for the UM Program Evaluation includes Q4 2020 through the end of Q3 2021. During 2021, the scope and oversight of the UM Program was enhanced to include dedicated staff to monitor and oversee UM functions on an ongoing basis. A new unit for oversight was implemented to monitor timeliness, clinical decision making, and notification protocols.

The most significant finding in the program evaluation for 2021 was identified for Q3 2021. The UM department experienced a growing number of aging cases that fell out of turn-around-time compliance. Early efforts were implemented by UM leadership to mitigate the backlog of aged-out inventory but failed due to oversight and accountability, strategic planning, and other process and system issues.

Additionally, throughout the lookback period UM leadership initiated several projects to support improved efficiency, decreased administrative burden, and improved quality of provider and member-facing documentation. Some of these projects included:

- System upgrades/enhancements;

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- Reporting and leadership oversight tools;
- Updated policies and procedures; and
- Expansion of under-and over-utilization tools to target trends.

Some notable outlier outcomes that were noted in the 2021 evaluation include but are not limited to:

- ED utilization spike in TANF during the reporting period;
- Increase in Average length of stay in Q4 2020-Q2 2021(likely due to COVID); and
- Overutilization of prenatal ultrasounds by an individual provider.

Evaluation Section	**2021 highlights**
Scope	Added UM monitoring unit July 2021.
Projects, Programs, and Initiatives	UM inventory backlog noted July 2021. Projects implemented to improve efficiency, decrease administrative burden, and improve quality.
Delegated Provider Oversight	Outlines activities of the UM monitoring unit.
Performance	Outlines variation in performance and volume changes in online and fax referrals. Pharmacy and LTSS consistently met TAT and annual IRR was completed with compliant results.

2022 UM Program Description

The UM Program Description is a regulatory document that outlines the components of CalOptima's UM program and oversight to demonstrate compliance with state, federal, and quality UM program requirements. Annually, at a minimum, the UM program description is updated to reflect changes and enhancements to the UM program based on the previous year's evaluation. The following outlines 2022 changes to the CalOptima UM Program Description:

UM Program Section	**Changes**
Program Initiatives: COVID-19	Impact of COVID during 2021, including adverse impact on mental health and health care inequities by race and ethnicity.
DHCS Quality Strategy	DHCS strategy and vision for Medi-Cal including CalOptima's shared strategy and guiding principles.
CalAIM	DHCS multiyear initiative including enhanced care management and community supports.
Pharmacy Program	Pharmacy carve out to Medi-Cal RX effective January 1, 2022.

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UM Program Section	Changes
UM Scope	Changes to clarify and update scope of program to include access to appropriate services, providers, and care settings. Additionally, added content to include areas of integrated behavioral health and post-stabilization services.
Program Goals	Monitoring of practitioner utilization patterns to include variations of individual providers and identify opportunities for education and support.
Program Structure	Clarified oversight and evaluation of the program to identify officer ownership and committee oversight.
Review and Authorization of Services	Specifics of the EPSDT program were updated to include DHCS expanded coverage for members under 21.
Review and Authorization of Services	Non-material addition of specific policy references to ensure alignment between policies and program.
Timeliness of UM Decisions	Reflect current standards for all LOBs and enhancements to resolve inventory out of compliance and prevent future backlog
Authorization for Post Stabilization Services	Clarification on responsibility for determining whether the member is stable and responsibility of providers related to determining stabilization.

Fiscal Impact

The recommended action to approve the 2022 Utilization Management Program does not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2021-22 Operating Budget and separate Board actions. Staff will include updated expenditures for the period of July 1, 2022, through December 31, 2022, in the FY 2022-23 Operating Budget.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2021 UM Program Evaluation – Clean Copy
2. 2021 UM Program Evaluation – Redline Copy
3. 2022 UM Program – Clean Copy
4. 2022 UM Program – Redline Copy

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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2021 CalOptima Utilization Management Program Evaluation

I. Executive Summary

The 2021 Utilization Management (UM) Program description outlines CalOptima's activities to provide optimal utilization for members with access to quality health care services delivered in a cost-effective and compassionate manner.

Annually, CalOptima evaluates the UM program structure, scope, processes, an information sources used to determine benefit coverage and medical necessity. This evaluation of UM activity is approved annually by the UM Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors. The annual look back period UM program evaluation looks at the Q4'2020 through the end of Q3'2021

During 2021, the scope and oversight of the UM program was enhanced to ensure member needs are address, while maintaining compliance with recognized regulatory and accreditation standards. As a result, the following positions were added:

- The UM Monitoring unit was added to ensure compliance with all regulatory standards and provide oversight to our delegated health networks (HN). The staff added include:
  - Manager UM Monitoring who oversees the day-to-day operations of the functional area
  - Five clinical auditors who provide monthly monitoring of internal and delegate UM files

Outside of the changes indicated with the addition of the monitoring functional area as listed above, the structure and process of the UM department has not changed in relation to UM staff assigned activities. This includes those who have the authority to deny coverage, designated physician and behavioral health care practitioner involvement in the program, evaluation and development and approval of the UM program, process for handling appeals and making appeal determinations, as well as rule out within the organization related to the QI program and QI activities. Additionally, information sources used to determine benefit coverage and medical necessity remained current and appropriate. These are reviewed and approved annually at the UMC.

II. Projects, Programs and Initiatives

A. Utilization Management

In Q3 '2021, the UM department experienced a growing number of aging cases that fell out of turn-around-time compliance. Early efforts were implemented by UM leadership to mitigate the backlog of aged out inventory, but failed due to oversight and accountability, strategic planning and other process and system issues. Utilization management leadership also initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. Some of these projects included:

- Upgrades/enhancements to the Guiding (GC) Care Utilization Review Module in CalOptima's medical management system.
- Continued development of reporting and leadership oversight tools to ensure accountability, transparency and alignment.
- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes.
- Extended authorization time frames, relaxing UM requirements for those members impacted by the public health emergency COVID-19 pandemic, as well as tracking and reporting of positive members, hospitalizations, and deaths.
- Established ongoing process for evaluation and enhancement to the organization wide over and underutilization monitoring process to ensure members receive the appropriate care, timely and frequency to keep them well.
- Increased oversight of post-stabilization process to ensure that members requiring post stabilization care are afforded that care and compliant with regulatory requirements.

The Medical Director who oversees the UM program supported the UM process by providing clinical oversight for the administration of the UM Program and was very engaged during this year. He/she also supported the UM process through review of outcomes in UMC to ensure compliance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluated the program's effectiveness against established goals. The backlog of treatment authorization requests was not adequately communicated to UMC upon identification. There was a lack of oversight and transparency from UM leadership, including executive leaders to adequately report turn-around-time compliance through the committee structure.

The Medical Director oversaw provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). This committee evaluates new and modified benefits to determine the need for prior authorization and it led by the Medical Director overseeing the UM program. Those services not requiring PA led to provider and member satisfaction by allowing the provider to administer these services in a timely manner due to not requiring a PA. The Medical Director also chaired the bi-weekly UMWG and provided input to the development and processes of UM Program to ensure quality, cost-effective services and care are delivered to CalOptima members to meet their medical needs. The Medical Director led discussions with the nursing and physician group in semiweekly concurrent review case rounds, and discussed appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisted with discharge planning management. The director also provided education to the team to ensure understanding of the clinical basis for decisions.

The Medical Director also provided focused education on specific topics including genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

The Medical Director overseeing the Behavioral Health Program (BH) was also very involved in the UM program development and administration. This was evidenced by providing input on the program to ensure all BH activities were integrated and aligned with the medical program and ensured compliance with UM regulatory and accreditation requirements. The Medical Director also participated in the UMWG, UMC and BMSC meetings to ensure adequate representation of BH and ensure that members BH needs are identified, considered and handled appropriately. The Medical Director also represented CalOptima at various meetings and collaborations related to the BH needs of the population and transgender services, including Orange County work groups focused on this

population and working with Orange County Legal Aid to ensure services are provided to this population. The Director was very involved in the formation and implementation of policies and procedures, to ensure that appropriate changes are made based on state and federal guidance that was received throughout the year such as All-Plan Letters and other sources of regulatory updates.

In 2021, both the Medical Director overseeing the UM program and the Medical Director overseeing BH supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In 2021, CalOptima continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination and Quality Improvement (QI). The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines.

For OneCare (OC) and OneCare Connect (OCC), CalOptima successfully transitioned in 2020 the management of behavioral health (BH) benefits from Magellan Health to CalOptima internal operations similar to the structure we have established for Medi-Cal. The BHI department continues to be directly responsible for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

The Behavioral Health Quality Improvement (BHQI) subcommittee was retired in 2020. Objectives of this subcommittee were incorporated into CalOptima's committee structure including QIC, UMC, Member Experience Committee (MEMX), and Grievances, Appeals, and Resolutions (GARS) subcommittee. The goal is to further enhance the integration of behavioral health into CalOptima's programs and functions. The BH Medical Director and Directors of Behavioral Health Services participated in QIC and other subcommittees. In addition, Orange County Mental Health Plan Medical Director was added to the QIC membership to promote behavioral health integration for individuals with severe and persistent mental illness. In 2021 the BHQI workgroup continued to meet on a monthly basis to develop and implement BH quality initiatives. This internal group served to address suggestions from QIC and other subcommittees to identify areas of improvement, strengthen interventions, review performance data and improve the member experience.

C. UM Data Management

The UM data report's design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Technology Services (ITS) department staff. Together with UM department subject matter experts, EA and ITS maintained a focused effort to improve the visibility and understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima and the delegated health networks (HNs). Further refinement of daily inventory for prioritization was initiated in Q3'21 to address the backlog of treatment authorization requests inventory. Additionally, enhanced protocols, including data (XML) file format for HN submission of data elements included authorization information that led to increased reliability of reports and improved the usefulness of information. Additional efforts are planned to leverage availability of this information to UM, Quality Improvement and Audit and Oversight (A&O) by configuring standard queries of the data mart.

D. UM Delegated Provider

Oversight

The external Audit and Oversight (A&O) department within CalOptima, provides HN oversight to ensure HN compliance with regulatory requirements. Their oversight is comprised of in-depth annual audit of each HN to ensure compliance with CalOptima and regulatory requirements. HN performance is monitored via a monthly delegation oversight dashboard, which is segmented by line of business. This dashboard includes performance for all aspects of A&O monitoring, including UM, as well as the identification of trends. A&O provided corrective action plans (CAPs) to those HN who were not meeting delegation requirements. It is also worth noting that due to the COVID-19 pandemic, it was necessary to suspend some of the monthly audits, which impacts overall performance of the HNs. All monthly monitoring functions were to be transitioned to the UM Monitoring team effective July 1, 2021, and opportunities for improvements were identified through a pre-CAP process to the delegates. Collaboration with the external A&O dept was completed to develop CAPs when performance issues persisted for three months or greater.

Areas of focus for the monthly audits are:

- **Timeliness**: Meeting turnaround time (TAT) for routine and urgent authorization requests related to timeliness of decision and notification. The goal for this metric is 98% or greater.
- **Clinical decision making**: Appropriateness of clinical decision making for authorization requests approved, denied or modified.
- **Notifications**: Compliance with regulatory standards related to member notification of denials by reviewing the Notice of Action sent to the member indicating that the service was denied or modified.

Medi-Cal

HN oversight performance below, reveals that there are opportunities to improve TAT for urgent authorization requests, clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

Medi-Cal 2021 Delegated HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=12)	Issues Identified
Routine TAT Timeliness	99.4–100%	11	N/A
Urgent TAT Timeliness	96.62–99.82%	10	Failure to meet expedited TAT consistently
Clinical Decision Making	67–99.6%	7	Failure to cite criteria used in making the medical necessity determination, failure to obtain clinical info to support the request and failure to use the appropriate professional for making the clinical decision

Notifications	78–100%	8	Failure to use lay language to describe why a service did not meet criteria, notifications to member not in threshold language, failure to provide peer-to-peer with medical reviewer and failure to indicate the name and contact information for healthcare professional responsible for the decision to deny

The A&O department issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as, but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations. A year-over-year improvement is noted for both clinical decision making and notifications, as 2020 scores reflected only 3 HN within compliance for both metrics.

OCC

HN oversight performance below reveals that there are opportunities to improve clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

OneCare Connect 2021 Delegated HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=10)	Issues Identified
Routine TAT Timeliness	99.7–100%	10	N/A
Urgent TAT Timeliness	99.56–100%	10	N/A
Clinical Decision Making	56–100%	3	Failure to cite criteria for decision making
Notifications	63–100%	5	Failure to cite criteria for decision, failure to provide notification in members preferred language and lack of lay language description in notification to member.

A&O issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations within regulatory requirements. Year-over-year performance did not demonstrate significant improvement.

OC

HN oversight performance below reveals that there are opportunities to improve TAT, clinical decision making, and notification sent to the members about the decision for the authorization request. It is worth noting that OC has 1,601 members across 8 HNs, which means 1 non-compliant file will decrease compliance below the threshold of 98%.

OneCare 2021 HN Delegated Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=8)	Issues Identified
Routine TAT Timeliness	91.88–100%	5	Failure to provide timely provider notification
Urgent TAT Timeliness	85.19–99.41%	4	Failure to provide timely provider notification
Clinical Decision Making	60–100%	5	Use of lay language to identify why request did not meet criteria, failure to cite criteria for decision and failure to use CMS notification template.
Notifications	50–100%	5	Failure to describe why request did not meet lay language

CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements. Year-over-year showed a slight improvement in performance.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal Shared Risk

- **Average Length of Stay (ALOS):** For Seniors and Persons with Disabilities (SPD) and Temporary Assistance for Needy Families (TANF) >18 aid code categories, trended downward from the final quarter of 2020 through the second quarter in 2021 with a slight uptick in the third quarter 2021. The ALOS trend for members in TANF ≤ 18 aid code category shows uptick in ALOS during first quarter 2021 and then a downward progression through third quarter.
- **Bed Days/Per Thousand Members Per Year (PTMPY):** SPD and TANF > 18 population exceeded and did not meet the goal in fourth quarter 2020, however, a downward trend is noted during first and second quarter 2021, with an uptick in third quarter. The TANF ≤ subpopulation consistently met the 2021 goal.
- **Readmissions:** The SPD subpopulation demonstrated a downward trend from fourth quarter 202 through third quarter 2021. Both TANF subpopulations showed a decrease from fourth quarter to first quarter 2021, however an uptick is noted during quarter two and three of 2021.
- **ED Visits/PTMPY:** All three subpopulations are below goal through second quarter 2021, with an uptick noted for during third quarter and TANF > 18 above the goal.

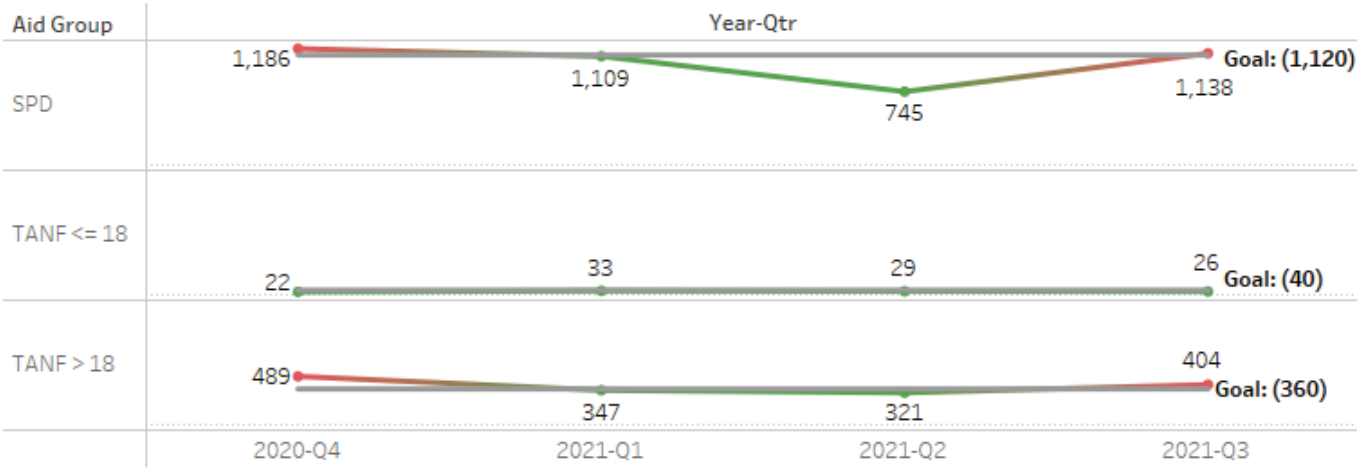
Utilization Outcomes

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	6.26	6.22	4.50	5.90
	Bed Days PTMPY	1185.96	1,108.51	745.06	1,138.37
	Pcnt Re-Admits	25.57%	19.80%	17.86%	16.55%
	ED Visits PTMPY	528.95	469.49	530.23	555.68
TANF > 18	ALOS	5.19	4.34	4.03	4.54
	Bed Days PTMPY	489.44	346.82	321.23	403.84
	Pcnt Re-Admits	11.45%	9.57%	10.57%	10.95%
	ED Visits PTMPY	399.18	354.52	397.45	438.36
TANF <= 18	ALOS	2.87	4.21	3.22	2.84
	Bed Days PTMPY	22.03	33.12	28.83	26.12
	Pcnt Re-Admits	1.16%	1.02%	2.78%	3.87%
	ED Visits PTMPY	150.58	140.75	205.41	256.54

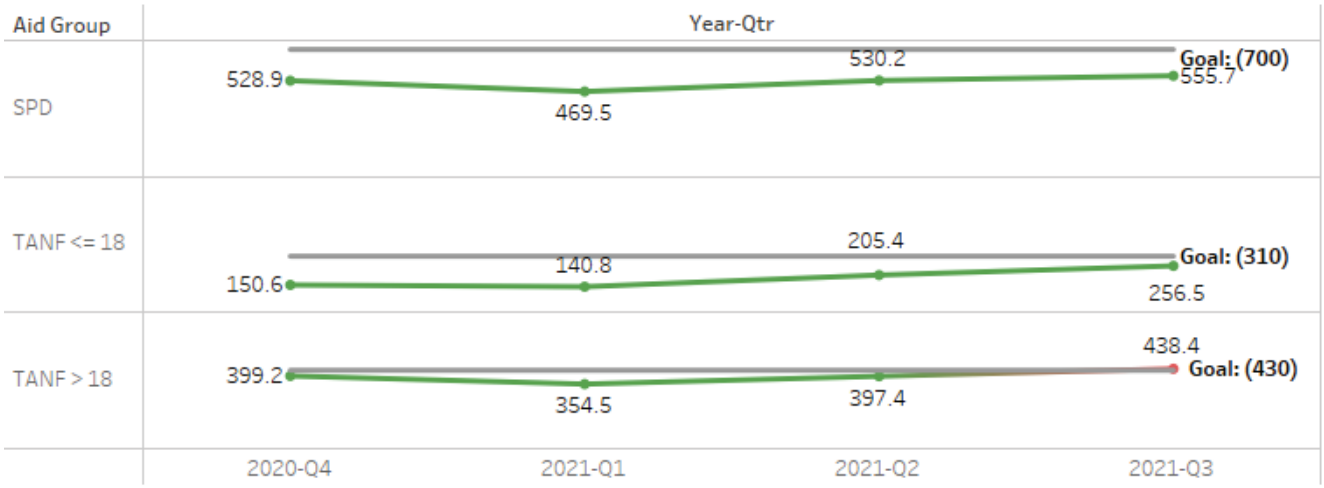
IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr: Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,120	1,186 ▲	1,109 ▼	745 ▼	1,138 ▲
TANF <= 18	40	22 ▼	33 ▼	29 ▼	26 ▼
TANF > 18	360	489 ▲	347 ▼	321 ▼	404 ▲

Legend: Goal Met, Not Met

ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	700	528.9 ▼	469.5 ▼	530.2 ▼	555.7 ▼
TANF <= 18	310	150.6 ▼	140.8 ▼	205.4 ▼	256.5 ▼
TANF > 18	430	399.2 ▼	354.5 ▼	397.4 ▼	438.4 ▲

Legend: Goal Met; Not Met

Medi-Cal CCN

- **Average Length of Stay**
  - **SPD:** Decrease noted in quarter two 2021 from previous two quarters, however, increase in ALOS during third quarter 2021.
  - **TANF <= 18:** Steady quarter-over-quarter uptick from fourth quarter 2020 through third quarter 2021.
  - **TANF > 18:** Uptick noted during second and third quarter 2021 with a decrease noted in third quarter.
- **Bed Days/PTMPY:** SPD bed days demonstrated a decrease during second quarter 2021 and a slight uptick in third quarter 2021, but remained below the established goal of 1,830/K. TANF ≤ 18 was below goal during fourth quarter 202 and second quarter 2021 but was above the established goal of 100/K during first and third quarter 2021. TANF > 18 was consistently about the goal of 710/k throughout the four measurement quarters.
- **Readmissions:** All three subpopulations showed a decrease in readmissions throughout the measurement period. It is noted that the TANF ≤ 18 did not have any members readmitted during fourth quarter 2020 and second quarter 2021.
- **ED Visits/PTMPY:** Both the SPD and TANF > 18 were above goal throughout the measurement period, however TANF ≤ remained below goal, demonstrated a quarter-over-quarter increase.

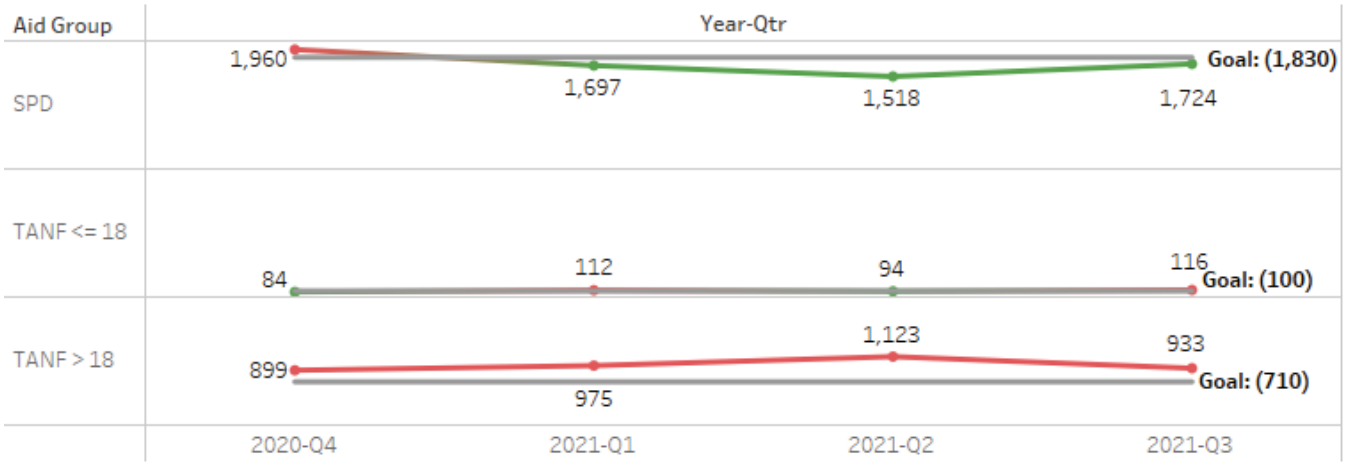
Utilization Outcomes

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	6.68	6.65	5.54	6.17
	Bed Days PTMPY	1959.67	1,697.13	1,517.72	1,723.88
	Pcnt Re-Admits	21.98%	20.09%	17.93%	17.77%
	ED Visits PTMPY	733.13	813.85	899.86	837.39
TANF > 18	ALOS	4.25	5.44	5.82	4.92
	Bed Days PTMPY	899.12	975.46	1123.37	932.70
	Pcnt Re-Admits	7.72%	7.84%	8.10%	7.24%
	ED Visits PTMPY	559.53	639.03	769.01	647.59
TANF <= 18	ALOS	4.66	4.95	5.44	5.93
	Bed Days PTMPY	83.62	111.90	94.26	115.51
	Pcnt Re-Admits	0.00%	4.03%	0.00%	6.43%
	ED Visits PTMPY	203.17	209.57	288.90	346.19

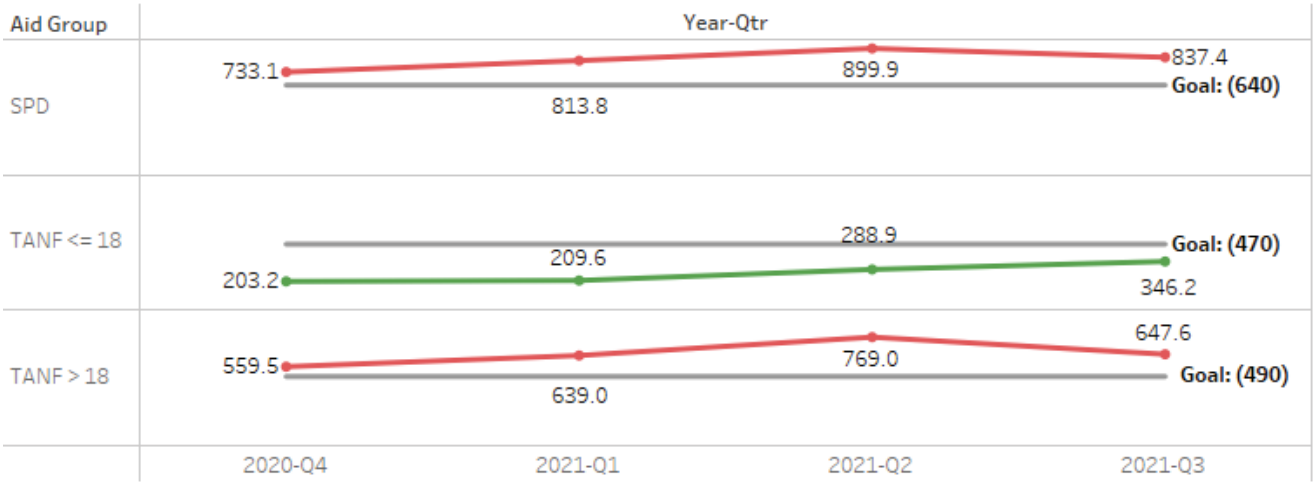
IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,830	1,960 ▲	1,697 ▼	1,518 ▼	1,724 ▼
TANF <= 18	100	84 ▼	112 ▲	94 ▼	116 ▲
TANF > 18	710	899 ▲	975 ▲	1,123 ▲	933 ▲

Legend: Goal Met, Not Met

ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	640	733.1 ▲	813.8 ▲	899.9 ▲	837.4 ▲
TANF <= 18	470	203.2 ▼	209.6 ▼	288.9 ▼	346.2 ▼
TANF > 18	490	559.5 ▲	639.0 ▲	769.0 ▲	647.6 ▲

Legend: Goal Met; Not Met

CalOptima Direct Administrative (CODA)

- **Average Length of Stay:** For the SPD and TANF > 18 subpopulations, ALOS trended down from fourth quarter 2020 through second quarter 2021, then significantly increased during third quarter 2021. The TANF ≤ 18 subpopulation spiked from fourth quarter 2020 to first quarter 2021, then shoed a decrease in ALOS in second and third quarter.
- **Bed Days/PTMPY:** Both SPD and TANF ≤ 18 did not meet the goal, however, although SPD did meet during first quarter 2021. TANF > 18 did not meet the goal for fourth quarter 2020 and third quarter 2021, but did reach the goal, but did meet first and second quarter goals in 2021.
- **Readmissions:** SPD readmissions did reveal a downward trend for all four quarters during the measurement period. TANF > 18 and ≤ 18 did show a downward trend, but both subpopulations demonstrated an increase in readmissions during third quarter 2021.
- **ED Visits/PTPMY:** Both SPD and TANF ≤ 18 were consistently below goal during the period. TANF > 18 was above goal, with a significant spike in second quarter, which decreased in third quarter, but was above goal.

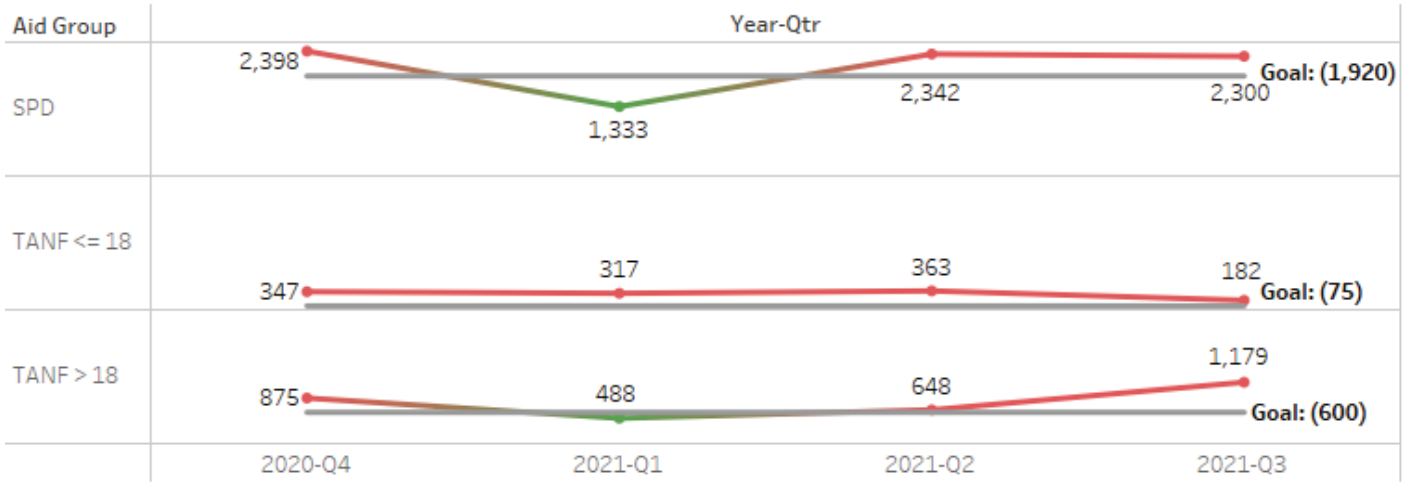
Utilization Outcomes

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	8.70	5.04	7.11	10.28
	Bed Days PTMPY	2397.96	1,332.77	2,342.36	2,299.78
	Pcnt Re-Admits	36.11%	27.35%	23.38%	12.43%
	ED Visits PTMPY	673.47	1047.90	869.23	796.42
TANF > 18	ALOS	6.07	4.06	4.73	6.01
	Bed Days PTMPY	875.27	488.04	647.64	1178.87
	Pcnt Re-Admits	9.38%	7.68%	0.00%	13.33%
	ED Visits PTMPY	412.90	476.69	2509.32	574.49
TANF <= 18	ALOS	7.95	9.15	7.98	5.39
	Bed Days PTMPY	347.02	316.51	362.58	182.19
	Pcnt Re-Admits	13.18%	11.47%	2.96%	10.61%
	ED Visits PTMPY	218.15	154.73	267.96	371.89

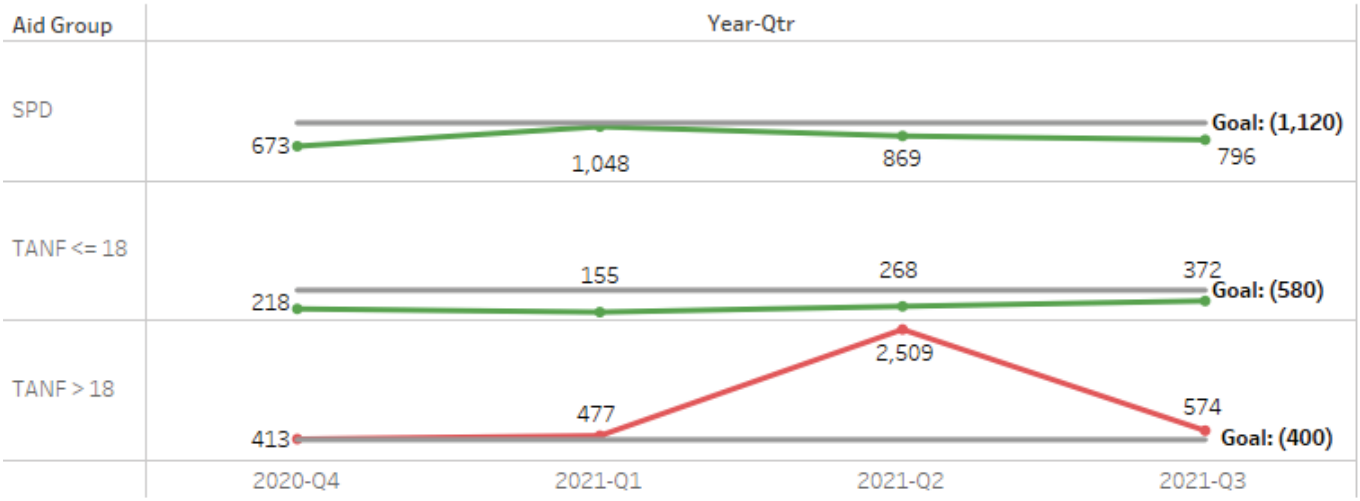
IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr: Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,920	2,398 ▲	1,333 ▼	2,342 ▲	2,300 ▲
TANF <= 18	75	347 ▲	317 ▲	363 ▲	182 ▲
TANF > 18	600	875 ▲	488 ▼	648 ▲	1,179 ▲

Legend: Goal Met; Not Met

ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,120	673 ▼	1,048 ▼	869 ▼	796 ▼
TANF <= 18	580	218 ▼	155 ▼	268 ▼	372 ▼
TANF > 18	400	413 ▲	477 ▲	2,509 ▲	574 ▲

Legend: Goal Met, Not Met

OneCare Connect Shared Risk

- **Average Length of Stay:** ALOS showed a steady decline throughout the measurement period, with a slight uptick for SPD during third quarter 2021.
- **Bed Days/PTMPY:** SPD subpopulation was slightly above goal during fourth quarter 202 and met goal for the remaining three quarters of the measurement period. No established goal for the TANF > 18, however bed days did reveal a significant uptick in second quarter 2021.
- **Readmissions:** Both SPD and TANF show volatile readmission rates for all four quarters with the TANF group jumping rapidly to 75% in Q3 2021.
- **ED Visits/PTMPY:** SPD ED visits consistently met the goal for all four quarters. The TANF >18 group does not have an established goal but did demonstrate a significant spike in ED use during second quarter 2021 and then fell to its lowest level in third quarter.

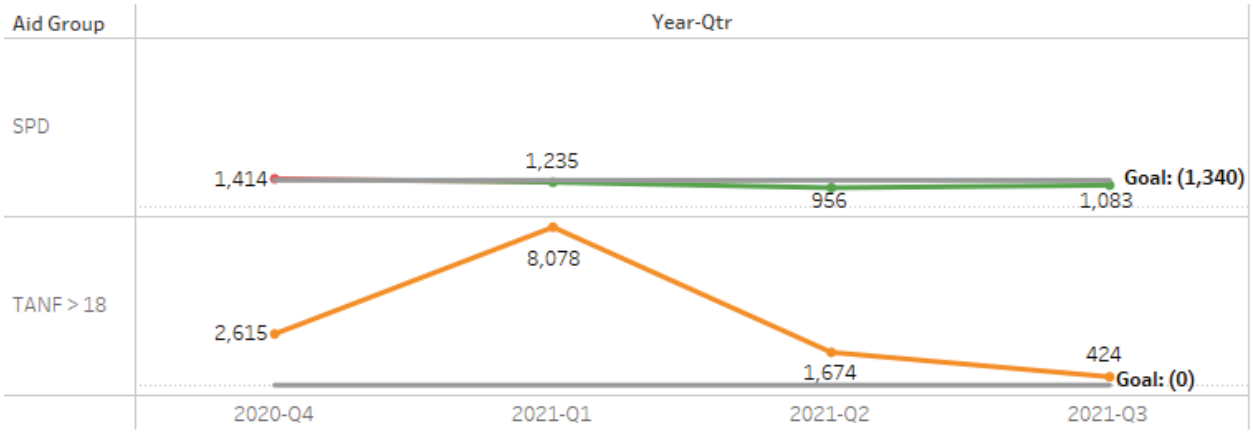
Utilization Outcomes

Line of Business: OCC Risk Group: Shared Risk - OCC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.16	6.51	5.29	5.73
	Bed Days PTMPY	1413.65	1,235.19	956.08	1,083.16
	Pcnt Re-Admits	16.14%	17.22%	5.88%	8.61%
	ED Visits PTMPY	298.19	286.83	330.83	359.43
TANF > 18	ALOS	8.00	15.85	4.00	2.60
	Bed Days PTMPY	2614.79	8078.43	1674.42	423.91
	Pcnt Re-Admits	42.86%	10.26%	16.67%	0.00%
	ED Visits PTMPY	560.31	588.24	2442.48	391.30

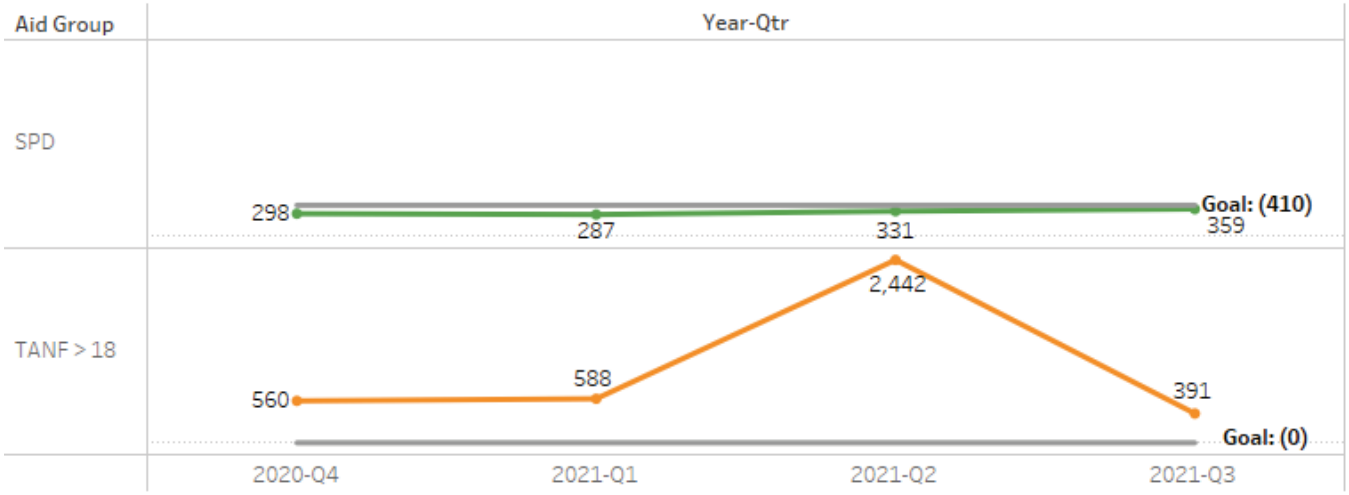
IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr: Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,340	1,414 ▲	1,235 ▼	956 ▼	1,083 ▼
TANF > 18	0	2,615	8,078	1,674	424

Legend: Goal Met | No Goal | Not Met

ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	410	298 ▼	287 ▼	331 ▼	359 ▼
TANF > 18	0	560	588	2,442	391

Legend: Goal Met, No Goal

OneCare Connect CCN

- **Average Length of Stay:** Both subpopulations demonstrated a downward trend in ALOS throughout the measurement period.
- **Bed Days/PTPMY:** SPD met the goal throughout the measurement period with a downward trend noted. TANF > 18 does not have an established goal, however there was a spike noted in first quarter 2021, which decreased in second quarter with a significant drop in third quarter 2021.
- **Readmissions:** SPD demonstrated a downward trend in readmission rates throughout the measurement period. TANF > 18, however, did not have any readmissions noted from fourth quarter 2020 through second quarter 2021 and then demonstrated a significant spike in third quarter 2021.
- **ED Visits/PTPMY:** SPD was consistently above goal throughout the measurement period, with TANF > 18 extremely variable throughout the measurement period trending downward from fourth quarter 2020 to second quarter 2020, with a significant spike in ED usage during third quarter 2021.

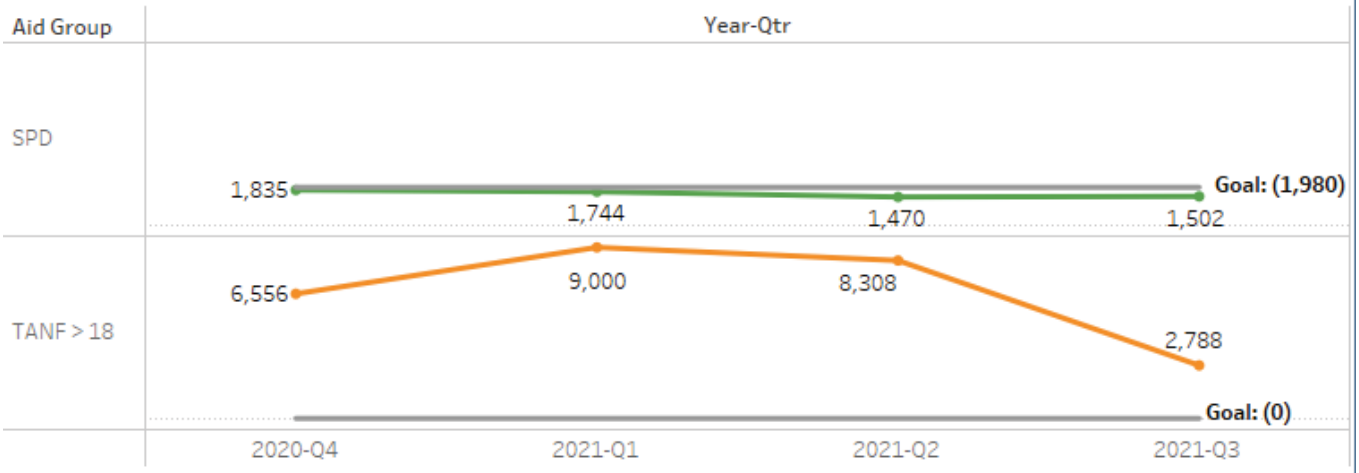
Utilization Outcomes

Line of Business: OCC Risk Group: CCN OCC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.10	6.08	5.54	5.43
	Bed Days PTMPY	1835.22	1,744.35	1,469.62	1,501.68
	Pcnt Re-Admits	16.84%	17.48%	13.17%	9.41%
	ED Visits PTMPY	501.23	456.24	468.58	512.72
TANF > 18	ALOS	28.00	14.73	9.56	5.09
	Bed Days PTMPY	6556.10	9000.00	8307.69	2788.38
	Pcnt Re-Admits	0.00%	0.00%	0.00%	27.27%
	ED Visits PTMPY	819.51	555.56	434.39	1145.23

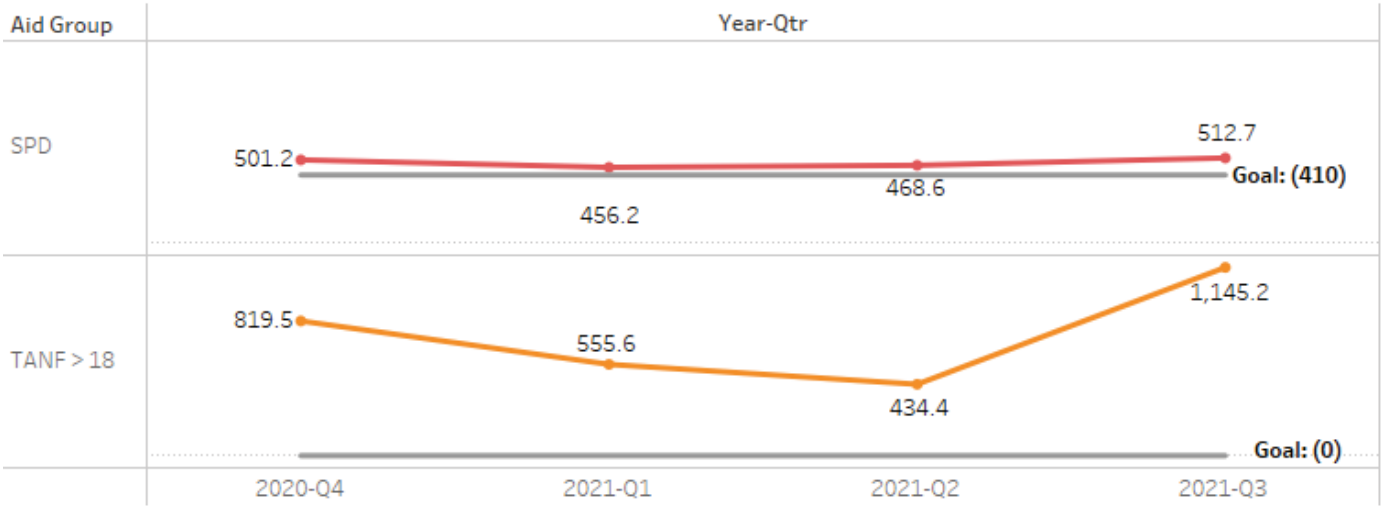
IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr: Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,980	1,835 ▼	1,744 ▼	1,470 ▼	1,502 ▼
TANF > 18	0	6,556	9,000	8,308	2,788

Legend: Goal Met; No Goal

ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	410	501.2 ▲	456.2 ▲	468.6 ▲	512.7 ▲
TANF > 18	0	819.5	555.6	434.4	1,145.2

Legend: No Goal, Not Met

OneCare

- **Average Length of Stay:** The SPD population trended downward from fourth quarter 2020 through first quarter 2021with an uptick during second quarter that slightly decreased third quarter 2021.
- **Bed Days/PTPMY:** The SPD population consistently met the goal, trending downward for all four quarters, with the exception of Q2 2021.
- **Readmissions:** The SPD population demonstrated an uptick in readmissions during first quarter and a significant uptick in second quarter 2021, then dropping significantly during third quarter.
- **ED Visits/PTPMY:** The SPD population consistently met the goal for all four quarters.

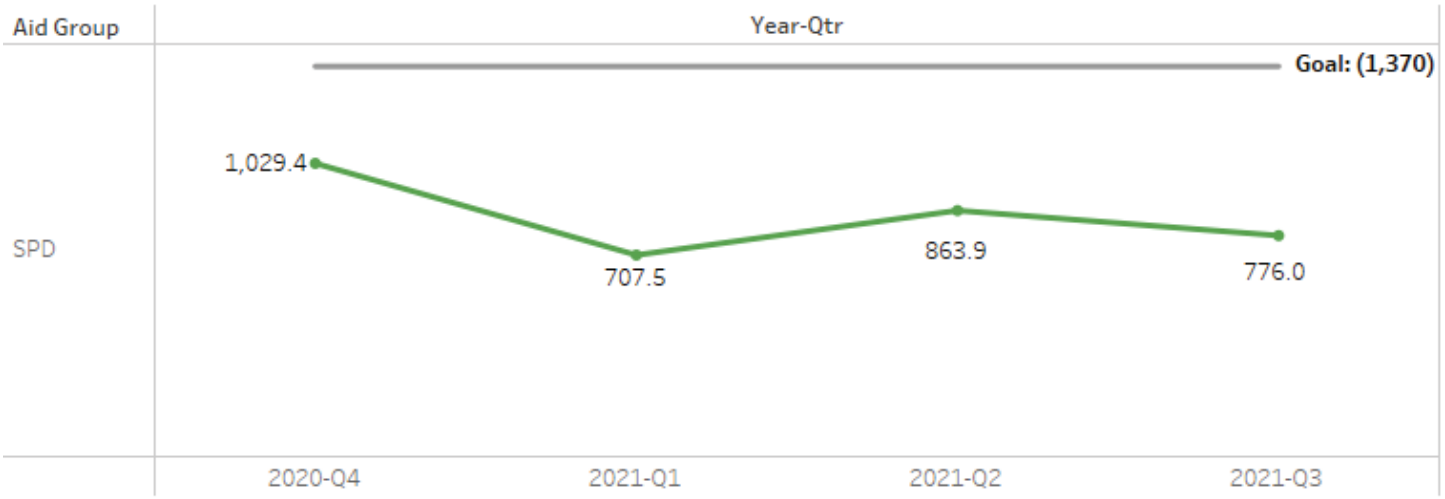
Utilization Outcomes

Line of Business: One Care Risk Group: OneCare

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.03	4.96	5.48	5.31
	Bed Days PTMPY	1029.44	707.53	863.86	775.98
	Pcnt Re-Admits	7.90%	11.90%	31.05%	3.45%
	ED Visits PTMPY	348.19	249.42	259.16	251.94

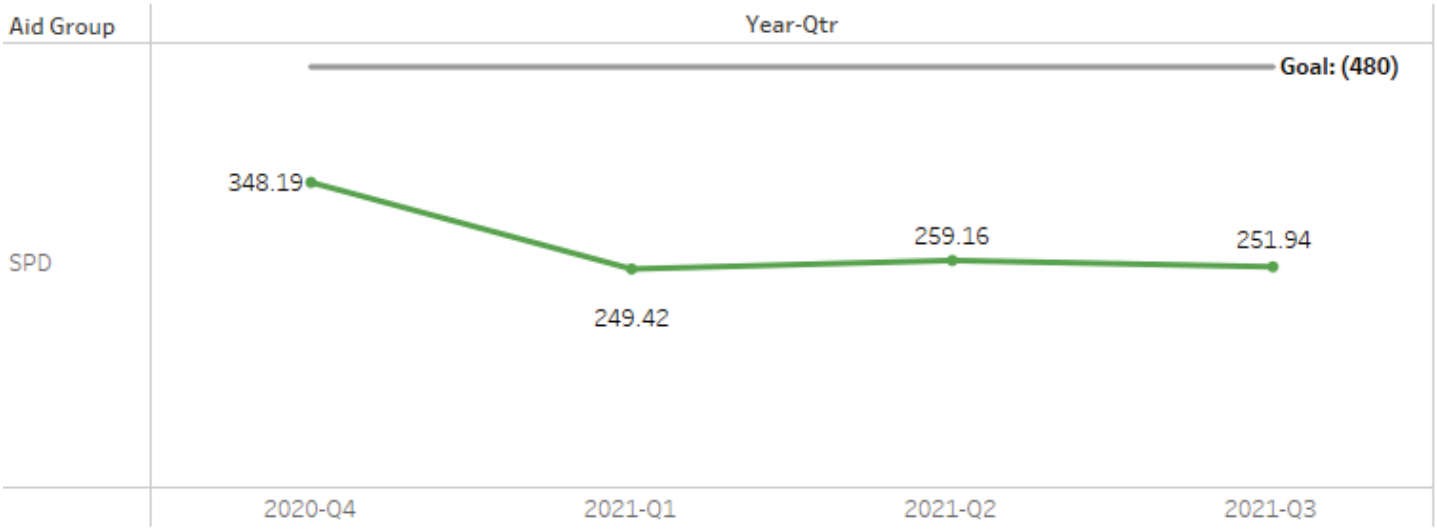
IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,370	1,029.4 ▼	707.5 ▼	863.9 ▼	776.0 ▼

Legend
Goal Met

ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	480	348.19 ▼	249.42 ▼	259.16 ▼	251.94 ▼

Legend: Goal Met

As identified in section II A Utilization Management above, a significant backlog impacted the turnaround time for all LOBs during third quarter 2021. Efforts were introduced during fourth quarter 2021 that led to a resolution of the backlog in early 2022.

Turnaround Time Compliance (TAT) Q4 2020 - Q3 2021					
Years	**Quarters**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2020	**Qtr4**	Medi-Cal	99.83%	99.44%	99.96%
		OneCare	100.00%	-	-
		OneCare Connect	99.82%	94.12%	100.00%
2021	**Qtr1**	Medi-Cal	99.87%	99.65%	99.96%
		OneCare	100.00%	-	-
		OneCare Connect	99.85%	100.00%	100.00%
	Qtr2	Medi-Cal	99.69%	99.09%	99.77%
		OneCare	100.00%	-	100.00%
		OneCare Connect	100.00%	98.99%	100.00%
	Qtr3	Medi-Cal	64.99%	92.28%	99.59%
		OneCare	50.00%	100.00%	100.00%
		OneCare Connect	93.69%	97.85%	93.83%

An increase in Medi-Cal referrals can be seen quarter-over-quarter below with a significant increase during second quarter and a decrease during third quarter consistent with fourth quarter 2020 and first quarter 2021. These volumes demonstrate an increase over prior years.

Referrals Processed Q4 2020 - Q3 2021					
Years	**Quarters**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2020	**Qtr4**	Medi-Cal	35,130	3,731	2,275
		OneCare	11	-	-
		OneCare Connect	1,648	204	110
2021	**Qtr1**	Medi-Cal	36,352	4,247	2,289
		OneCare	11	-	-
		OneCare Connect	1,347	198	72
	Qtr2	Medi-Cal	40,313	4,526	2,577
		OneCare	14	-	1
		OneCare Connect	1,552	199	66
	Qtr3	Medi-Cal	36,857	5,270	2,199
		OneCare	12	1	1
		OneCare Connect	1,679	233	81
Grand Total			154,926	18,609	9,671

Referrals Received Q4 2020 - Q3 2021	
Faxes	119,300
COLAS	156,224
COLAS Auto Approved	52,262
Total	275,524

Over and Underutilization

In 2021 we continued to enhance the process for monitoring of over and underutilization as organization wide initiative to ensure appropriate monitoring of activities with CalOptima related to over and underutilization and the development of a cross departmental dashboard, maintained by UM. For 2021 we added performance for all CalOptima Medi-Cal members in order to include our health network data and look at the membership as a whole. Metrics were identified throughout the organization as good indicators of over and underutilization, as well as drill down into the metrics to ensure proper identification of over and underutilization. Metrics from the following area are included and will be reviewed on an annual basis to ensure they are indicative of over and underutilization monitoring. The metrics include inpatient and prior authorization UM measure, appeal volumes and overturn rate, member grievances, adult and children's access to PCP services, measures indicative of appropriate utilization for pharmaceuticals, outlier reporting from the fraud, waste and abuse department within CalOptima, referral pattern analyses, member utilization, UM related member complaints, potential quality issues (PQI) monitoring, and measures related to behavioral health care.

Over and underutilization was monitored, tracked, managed, and reported by UM during 2021 and reported to UMC, QIC and the Quality Assurance Committee (QAC). Through quarter 3 of 2021, we identified one area of overutilization related pre-natal ultrasounds being ordered by one physician multiple times, when the recommendation is one ultrasound within 180 days and any others within that period will require prior authorization. Provider education has occurred via a memo and by provider relation outreach.

III. Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests — Medical

2021 — Summary of referral volume (Q4 2020 to Q3 2021)

Referrals Processed		Referrals Received		Turnaround Time Compliance (TAT)	
Routine	**161,717**	Faxed	**119,300**	Routine TAT	**86.97%**
Urgent	**19,257**	COLAS	**156,224**	Urgent TAT	**96.90%**
Retro	**8,954**	Auto Auth	**52,262**	Retro TAT	**99.69%**
Total	**189,928***	**Total**	**275,524**		

- Total volume of referrals shows a year-over-year increase 8,607 (5.9%) based on data from Q1–3 2019 compared to Q4 2019 through Q3 2021.
- Volume of faxed referrals decreased from Q1–3 2019 by 9,800 or 10.9%
- Volume of portal (COLA) referrals decreased from 2019 report by 365 or .36%

We did work diligently to improve the non-compliant TAT by focusing efforts on active inventory, or inventory that would not age out of compliance if processed timely. As well as analyze staffing patterns and worked with human resources to backfill vacant full-time positions.

* The difference between referrals received and processed may be attributed to duplicate submissions and/or requests that do not require authorization.

Online Referral Rate Submission

Online referral submission increased over the 3 quarters by 11% in 2021. In 2019, Q1–Q3, there were 91,334 online referrals and during the same period of 2021, there were 100,177.

- Referral TAT was compliant for all referral types in the first 3 quarters of 2021.

B. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

Annual summary of turnaround time compliance through Q3 2021:

LOB	TAT Compliance
Medi-Cal	99.3%
OC	99.7%
OCC	99.5%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans. Pharmacy metric targets were achieved for 2021.

C. Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for Q4 2020–Q3 2021:
  - CBAS CEDT: 99.90%
  - CBAS Routine: 99.80%
  - CBAS Expedited: None received
    - Members participating in CBAS Q4 2020 & Q1–Q3 2021: Potentially program-eligible members.

Year	Qtr.	LOB	Members Participating in CBAS Q4 2019-Q3 2021 / Potentially Program-Eligible Members	% Participating	Change from Previous Qtr.
2020	Q4	Medi-Cal	2,405/121,676	1.98%	No Change
		OCC	158/15,055	1.05%	↓
2021	Q1	Medi-Cal	2,455/123,416	1.99%	↑
		OCC	160/14,764	1.08%	↑

	Q2	Medi-Cal	2,493/124,060	2.01%	↑
		OCC	145/14,806	0.98%	↓
	Q3	Medi-Cal	2,535/106,491	2.38%	↑
		OCC	152/14,852	1.02%	↑

- 80% of authorized CBAS participation days will be utilized/delivered Q4 2020) to Q3 2021.

Year	Qtr.	CBAS Participation Days Used / Days Authorized	% Used	Change from Previous Qtr.
2020	Q4	101,674/121,905	83.40%	↓
2021	Q1	105,716/121,927	86.70%	↑
	Q2	110,287/125,852	87.63%	↑
	Q3	133,811/158,466	84.44%	[OC1][OC2]↓

  - LTC Routine: 97.16%
  - LTC Urgent: None received
  - MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

Year	Qtr.	Admissions/ Discharges	Change from Previous Qtr.
2020	Q4	31 / 34	Admissions ↑
2021	Q1	33 / 21	Admissions ↑
	Q2	29 / 24	Admissions ↓
	Q3	25 / 13	Admissions ↓

- MSSP Goal met. Continue with this goal.

D. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were

achieved for 2021. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	96.13%
UM Clinical Staff: Concurrent Review	98.3%
Physicians	98.70%
Pharmacy	100%
LTSS: LTC	Not completed in 2021
LTSS: CBAS	Not completed in 2021
LTSS: MSSP	99%

E. Denial (Letter) Process

Performance has continued to improve throughout 2021. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains some variability across the HNs. A workgroup begun in 2021 consisting of participants from CalOptima UM, BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further improvement in this area. NCQA 2021 Survey demonstrated full compliance with the denial process across CCN and the HNs selected for review.

IV. Utilization Performance / Outcomes

A. Facility Utilization — Facility Acute and Emergency Care

Analysis of inpatient and ED data in 2021 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.

Review of 2021 ED Data will be conducted, and additional interventions may be applied as needed.
LTC Nursing facility members transitioned to the Community:

Year	Qtr.	LOB	LTC Nursing Facility Members Transition to the Community	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	182 / 5,133	3.55%	↑
		OCC	6 / 205	2.93%	↑
2021	Q1	Medi-Cal	163 / 5,181	3.15%	↓
		OCC	6 / 201	2.99%	↑

	Q2	Medi-Cal	148 / 5,192	2.85%	↓
		OCC	7 / 185	3.78%	↑
	Q3	Medi-Cal	158 / 4,738	3.33%	↑
		OCC	4 / 161	2.48%	↓

CBAS: Track CBAS participants who transition to LTC.

Yr.	Qtr.	LOB	CBAS participants who transition to LTC	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	8 / 2,590	0.31%	↑
		OCC	1 / 195	0.51%	↓
2021	Q1	Medi-Cal	10 / 2,565	0.39%	↑
		OCC	1 / 194	0.52%	↑
	Q2	Medi-Cal	4 / 2,345	0.17%	↓
		OCC	0 / 170	0.00%	↓
	Q3	Medi-Cal	7 / 2,384	0.29%	↑
		OCC	0 / 164	0.00%	←

LTC: Members residing in LTC: Potentially nursing home eligible members.

Year	Qtr.	LOB	Members Residing in LTC/ Potentially Nursing Home Eligible Members	% Residing in LTC	Change from Previous Qtr.
2019	Q4	Medi-Cal	5,133 / 116,443	4.41%	↓
		OCC	205 / 14,168	1.45%	↓
2021	Q1	Medi-Cal	5,181 / 114,555	4.52%	↑
		OCC	201 / 14,191	1.42%	↓
	Q2	Medi-Cal	5,192 / 105,321	4.93%	↑
		OCC	105 / 14,408	0.73%	↓
	Q3	Medi-Cal	4,738 / 120,253	3.94%	↓
		OCC	161 / 14,711	1.09%	↑

B. Pharmacy Utilization

- Retail Pharmacy: $PMPM costs from 4Q20 to 3Q21 are below goal for Medi-Cal, and above goal for OneCare and OneCare Connect. OneCare and OneCare Connect drug cost increases are primarily driven by increased utilization of diabetes medications as well as drug price increases for a large number of branded medications.

LOB	Goal $PMPM	Actual $PMPM (Q4 2019–Q3 2021)
Medi-Cal	$75.14	$72.30
OC	$389.29	$410.56
OCC	$441.46	$451.19

C. Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:

- Providing information to members and providers about the UM Program
  - Members are informed about authorization requirements through the Member Handbook and member newsletters.
  - New member orientation is available for all CalOptima members to better understand their benefits.
  - Access to a list of services requiring pre-authorization is also available on CalOptima's website.
  - CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed.
  - Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members.
  - A Provider Toolkit is available on the CalOptima website for provider reference.
  - CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers.
- Ensuring timeliness and notification of UM decisions
  - Monitored and reported quarterly to UMC: In 2021, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making.
  - Monitored monthly by the A&O Committee
  - Variation among the delegated HNs
  - Additional training provided as needed.
  - Overall improvement in audit scores for clinical decision making in 2021.

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 2021, complaints about the UM Program demonstrated some trends in the following categories:

- Member concerns:
  - Access to providers, specifically providers no longer contracted with CalOptima.
  - Provider not seeing new patients.
  - Provider was unable to see the member due to the type of care the member required or the members age was not in the scope of their specialty practice.
  - Limitation of members ability to see certain providers, as there are some providers who only see members already affiliated with their organization.

- Provider concerns:
    - Most complaints from providers were related to changes in our portal to safeguard PHI and inability for them to self-serve to obtain information about their referral.

CalOptima is continually looking at improving access to providers, including alternative types of visits, such as telehealth. All member issues were resolved by either redirecting the members care to another specialist that is able to meet the member's needs. We are looking at ways to improve provider data in our systems, including finding a new product to use for provider data management that interfaces with multiple systems. Provider relations has also worked very diligently to ensure the provider data is accurate, by confirming information accuracy with providers.

Access to authorization data has been mitigated by adding safeguards within the portal to verify the provider has a relationship with the member and displaying the members phone number only on authorization notices to limit PHI exposure and ensure the provider is able to reach out to the member to deliver necessary care.

V. SUMMARY

In 2021, UM encountered a backlog of treatment authorization requests identified in Q3'2021 and initiated early interventions that ultimately were unsuccessful in addressing the backlog of inventory and maintaining turn-around-time compliance. CalOptima implemented internal structural changes in attempt to improve the effectiveness of the UM program. CalOptima enhanced monitoring protocols internally to oversee delegated health networks. Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on Compliance, maintenance of current policies and procedures, report development.

The UMC and the UM Medical Director and Behavioral Health Medical Director continue to guide and support CalOptima UM programs, both medical and behavioral. The UMC met virtually six times in 2021 due to the public health emergency. Pharmacy and Therapeutics Committee (P&T) and the BMSC reported quarterly to the UMC in 2021. Quarterly UM operational performance and health care utilization data and over and underutilization analysis and trends are presented, reviewed, and discussed at the UMC and guide future efforts of the CalOptima UM Program.

~~2020~~2021 CalOptima Utilization Management Program Evaluation

I. Executive Summary

The ~~2020~~2021 Utilization Management (UM) Program description outlines ~~describes~~ CalOptima's activities to provide optimal~~um~~ utilization for members with access to quality health care services delivered in a cost-effective and compassionate manner.

Annually, CalOptima evaluates the UM program structure, scope, processes, an information sources used to determine benefit coverage and medical necessity. This evaluation of UM activity is approved annually by the UM Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors. The annual look back period UM program evaluation looks at the Q4'2020 through the end of Q3'2021

During ~~2020~~2021, ~~we broadened~~ the scope and oversight of the UM program was enhanced to ensure ~~we~~ member needs are address,~~adequately meeting our members need,~~ while maintaining compliance with recognized regulatory and accreditation standards. ~~Specifically, we added~~As a result, the following positions were added ~~the following roles~~:

- ~~Addition of a Custom Durable Medical Equipment (DME) Physical Therapist (PT) to complete in home assessments of members needing custom DME.~~
- ~~Addition of two (2) inline monitoring nurses to ensure compliance with internal UM activities and identification of opportunities for improvement to achieve and maintain compliance with regulatory and accreditation standards.~~The UM Monitoring unit was added to ensure compliance with all regulatory standards and provide oversight to our delegated health networks (HN). The staff added include:
  - Manager UM Monitoring who oversees the day-to-day operations of the functional area
  - Five clinical auditors who provide monthly monitoring of internal and delegate UM files

Outside of the changes indicated with the addition of the monitoring functional area as listed above, t~~T~~he structure and process of the UM department has not changed in relation to UM staff assigned activities. This includes those who have the authority to deny coverage, designated physician and behavioral health care practitioner involvement in the program, evaluation and development and approval of the UM program, process for handling appeals and making appeal determinations, as well as rule out within the organization related to the QI program and QI activities. Additionally, information sources used to determine benefit coverage and medical necessity remained current and appropriate. These are reviewed and approved annually at the UMC.

II. Projects, Programs and Initiatives

A. Utilization Management

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In Q3 '~~2020~~2021, the UM department experienced a growing number of aging cases that fell out of turn-around-time compliance. Early efforts were implemented by UM leadership ~~to attempt~~ to mitigate the backlog of aged out inventory, but failed due to oversight and accountability, strategic planning and other process and system issues. Utilization management leadership also initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. Some of t~~T~~hese projects included:

- Upgrades/enhancements to the Guiding (GC) Care Utilization Review Module in CalOptima's medical management system.
- ~~Identifying through data analysis those services that can be automatically authorized in the UM system without clinician review, to improve the throughput time to provide authorizations to members to timely access needed care.~~
- ~~Development of tools, such as documentation templates for physical therapy, occupational therapy and speech therapy Physical Therapy (PT), Occupational Therapy (OT) Speech Therapy (ST), as well as training focused on improving documentation requirements and UM processes in an effort to improve and maintain compliance with UM requirements.~~
- Continued development of ~~CalOptima Reporting Environment (CORE)~~reporting and leadership oversight tools ~~-~~to ~~align operational reports with the data structure in GC and to continue to identify opportunities for process improvement.~~ensure accountability, transparency and alignment.
- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes.
- Extended authorization time frames, relaxing UM requirements for those members impacted by the public health emergency COVID-19 pandemic, as well as tracking and reporting of positive members, hospitalizations, and deaths.
- ~~Fully developed an~~~~Continually~~ Established ongoing process for evaluation and enhancement to the organization wide over and underutilization monitoring process to ensure members receive the appropriate care, timely and frequency to keep them well.
- Increased oversight of post-stabilization process to ensure that members requiring post stabilization care are afforded that care and compliant with regulatory requirements.
-
- ~~Tested to determine if changing our staffing model to a POD approach, or a group of 3 nurses and 3 MAAs, would improve efficiency, consistency, and timeliness of authorization requests, which if successful would be spread to the entire prior authorization department in 2021.~~

The Medical Director who oversees the ~~of~~ UM program supported the UM process by providing clinical oversight for the administration of the UM Program and was very engaged during this year. He/she also ~~supported the~~supported the UM process ~~by ensuring that treatment requests~~through review of outcomes in UMC to ensure compliance ~~were processed in accordance~~ with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluated the program's effectiveness against established goals.

The backlog of treatment authorization requests was not adequately ~~identified and reported~~communicated to UMC upon identification. There was a lack of oversight and transparency from UM leadership, including executive leaders to adequately report turn-around-time compliance through the committee structure. ~~For UM Program areas that did not meet the approved goals, modifications to program activities were proposed by leadership to the UM Workgroup (UMWG). As endorsed by the UMWG, the updated plan was presented and approved by the UMC. Those changes were implemented by the UM Leadership and department staff.~~

The ~~UM~~ Medical Director ~~supported~~ oversaw provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). This committee evaluates new and modified benefits to determine the need for prior authorization and it led by the ~~UM~~ Medical Director overseeing the UM program. Those services not requiring PA led to provider and member satisfaction by allowing the provider to administer these services in a timely manner due to not requiring a PA. The ~~UM~~ Medical Director also chaired the bi-weekly UMWG and provided input to the development and processes of UM Program to ensure quality, cost-effective services and care are delivered to CalOptima members to meet their medical needs. The ~~UM~~ Medical Director led discussions with the nursing and physician group in semiweekly concurrent review case rounds, and discussed appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisted with discharge planning management. The director also provided education to the team to ensure understanding of the clinical basis for decisions.

The ~~UM~~ Medical Director also provided focused education on specific topics including genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

The ~~Behavioral Health (BH)~~ Medical Director overseeing the Behavioral Health Program (BH) was also very involved in the UM program development and administration. This was evidenced by providing input on the program to ensure all BH activities were integrated and aligned with the medical program and ensured compliance with UM regulatory and accreditation requirements. The ~~BH~~ Medical Director also participated in the UMWG, UMC and BMSC meetings to ensure adequate representation of BH and ensure that members BH needs are identified, considered and handled appropriately. The ~~BH~~ Medical Director also represented CalOptima at various meetings and collaborations related to the BH needs of the population and transgender services, including ~~Orange county~~Orange County work groups focused on this population and working with Orange County Legal Aid to ensure services are provided to this population. The Director was very involved in the formation and implementation of policies and procedures, to ensure that appropriate changes are made based on state and federal guidance that was received throughout the year such as All-Plan Letters and other sources of regulatory updates.

In ~~2020~~2021, both the ~~UM~~ Medical Director overseeing the UM program and the ~~BH~~ Medical Director overseeing BH supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In ~~2020~~2021, CalOptima continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination and Quality Improvement (QI). The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines.

For OneCare (OC) and OneCare Connect (OCC), CalOptima successfully transitioned in ~~2020~~ 2021~~0~~ the management of behavioral health (BH) benefits from Magellan Health to CalOptima internal operations similar to the structure we have established for Medi-Cal. The BHI department ~~is~~

~~now~~continues to be directly responsible for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

The Behavioral Health Quality Improvement (BHQI) subcommittee was retired in ~~2020~~20210. Objectives of this subcommittee were incorporated into CalOptima's committee structure including QIC, UMC, Member Experience Committee (MEMX), and Grievances, Appeals, and Resolutions (GARS) subcommittee. The goal is to further enhance the integration of behavioral health into CalOptima's programs and functions. The BH Medical Director and Directors of Behavioral Health Services participated in QIC and other subcommittees. In addition, Orange County Mental Health Plan Medical Director was added to the QIC membership to promote behavioral health integration for individuals with severe and persistent mental illness. In ~~2020~~2021 the BHQI workgroup continued to meet on a monthly basis to develop and implement BH quality initiatives. This internal group served to address suggestions from QIC and other subcommittees to identify areas of improvement, strengthen interventions, review performance data and improve the member experience.

C. UM Data Management

The UM data report's design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Technology Services (ITS) department staff. Together with UM department subject matter experts, EA and ITS maintained a focused effort to improve the visibility and understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima and the delegated health networks (HNs). Further refinement of daily inventory for prioritization was initiated in Q3'21 to address the backlog of treatment authorization requests inventory. Additionally, enhanced protocols, including data (XML) file format for HN submission of data elements included authorization information that led to increased reliability of reports and improved the usefulness of information. Additional efforts are planned to leverage availability of this information to UM, Quality Improvement and Audit and Oversight (A&O) by configuring standard queries of the data mart.

D. UM Delegated Provider Oversight

The external Audit and Oversight (A&O) department within CalOptima, provides HN oversight to ensure HN compliance with regulatory requirements. Their oversight is comprised of ~~monthly auditing of UM files, as well as other delegated functions, to ensure compliance. Additionally, it performs an~~ in-depth annual audit of each HN to ensure compliance with CalOptima and regulatory requirements. HN performance is monitored via a monthly delegation oversight dashboard, which is segmented by line of business. This dashboard includes performance for all aspects of A&O monitoring, including UM, as well as the identification of trends. A&O provided corrective action plans (CAPs) to those HN who were not meeting delegation requirements. It is also worth noting that due to the COVID-19 pandemic, it was necessary to suspend some of the monthly audits, which impacts overall performance of the HNs. All monthly monitoring functions were to be transitioned to the UM Monitoring team effective July 1, 2021, and opportunities for improvements were identified through a pre-CAP process to the delegates. Collaboration with the external A&O dept was completed to develop CAPs when performance issues persisted for three months or greater.

Areas of focus for the monthly audits are:

- **Timeliness**: Meeting turnaround time (TAT) for routine and urgent authorization requests related to timeliness of decision and notification. The goal for this metric is 98% or greater.
- **Clinical decision making**: Appropriateness of clinical decision making for authorization requests approved, denied or modified.

- **Notifications**: Compliance with regulatory standards related to member notification of denials by reviewing the Notice of Action sent to the member indicating that the service was denied or modified.

Medi-Cal

HN oversight performance below, reveals that there are opportunities to improve TAT for urgent authorization requests, clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

Medi-Cal ~~2020~~2021 Delegated HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=12~~1~~)	Issues Identified
Routine TAT Timeliness	~~98.8~~99.4–100%	~~11~~11	N/A
Urgent TAT Timeliness	96.62~~45~~–99.82%	~~3~~10	~~Did not meet TAT for urgent authorization requests, as well as member and provider notification timely~~Failure to meet expedited TAT consistently
Clinical Decision Making	67–99.6~~100~~%	~~3~~7	Failure to cite criteria used in making the medical necessity determination, failure to obtain clinical info to support the request and failure to use the appropriate professional for making the clinical decision
Notifications	7~~8~~5–100%	~~3~~8	Failure to use lay language to describe why a service did not meet criteria, notifications to member not in threshold language, failure to provide peer-to-peer with medical reviewer and failure to indicate the name and contact information for healthcare professional responsible for the decision to deny

The A&O department issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as, but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations. A year-over-year improvement is noted for both clinical decision making and notifications, as 2020 scores reflected only 3 HN within compliance for both metrics.

OCC

HN oversight performance below reveals that there are opportunities to improve clinical decision making, and notifications sent to members as a result of the decision for the authorization request.

OneCare Connect ~~2020~~2021 Delegated HN Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=10)	Issues Identified

Routine TAT Timeliness	99.7–100%	10	N/A
Urgent TAT Timeliness	99.568.57–100%	10	N/A
Clinical Decision Making	3356–100%	43	Failure to cite criteria for decision making
Notifications	7863–100%	5	Failure to cite criteria for decision, failure to provide notification in members preferred language and lack of lay language description in notification to member.

A&O issued requests for CAPs to all HNs with deficiencies identified during the focused review of prior authorization requests. A&O continues to work with each HN to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to — staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions — to ensure timely and accurate processing of authorizations within regulatory requirements. Year-over-year performance did not demonstrate significant improvement.

OC

HN oversight performance below reveals that there are opportunities to improve TAT, clinical decision making, and notification sent to the members about the decision for the authorization request. It is worth noting that OC has 1,601 members across 8 HNs, which means 1 non-compliant file will decrease compliance below the threshold of 98%.

OneCare 20202021 HN Delegated Oversight Performance

Metric: Threshold 98%	Performance Range	Compliant HN (n=8)	Issues Identified
Routine TAT Timeliness	67.1491.88–10099.78%	54	Failure to provide timely provider notification
Urgent TAT Timeliness	10.3785.19–97.599.41%	40	Failure to provide timely provider notification
Clinical Decision Making	6084–100%	5	Use of lay language to identify why request did not meet criteria, failure to cite criteria for decision and failure to use CMS notification template.
Notifications	5067–100%	5	Failure to describe why request did not meet lay language

CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements. Year-over-year showed a slight improvement in performance.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal Shared Risk

- **Average Length of Stay (ALOS):** For Seniors and Persons with Disabilities (SPD) and Temporary Assistance for Needy Families (TANF) >18 aid code categories, trended downward from the final quarter of 2020 through the second quarter in 2021 with a slight uptick in the third quarter 2021~~ALOS trended downward for the final quarter in 2019 and the first quarter of 20202021, and subsequently trended upward through the third quarter of 20202021~~. The ALOS trend for members in TANF ≤ 18 aid code category shows uptick in ALOS during first quarter 2021 and then a downward progression through third quarter. ~~a downward trend that holds steady for from the final quarter of 2019 2020 through the second quarter in 2020 2021 with a slight uptick dip in the third quarter 20202021.~~
- **Bed Days/Per Thousand Members Per Year (PTMPY):** SPD and TANF > 18 population exceeded and did not meet the goal in ~~Q4~~fourth quarter 2020, however, a downward trend is noted during first and second quarter 2021, with an uptick in third quarter. ~~decrease and remained the goal the first three quarters of 2021. and was below the goal.~~ The TANF ≤ ~~>18~~ subpopulation~~s~~ consistently met the ~~2020~~ 2021 goal~~, with only a slight increase exceeding the goal in Q3 2020 2021 for the SPD group. The TANF ≤ 18 exceeded the goal for every quarter except Q2 20202021subpopulation.~~.
- **Readmissions:** ~~Readmissions were fairly stable for the SPD and TANF >18all three subpopulations at approximately 25%-2320% and, 17%-16% respectively and 10%-6% respectively for all time periods.~~The SPD subpopulation demonstrated a downward trend from fourth quarter 202 through third quarter 2021. Both TANF subpopulations showed a decrease from fourth quarter to first quarter 2021, however an uptick is noted during quarter two and three of 2021. ~~TANF ≤18 ended 2019 at 12% and decreased to 8% for the first three quarters of 20202021.~~
- ~~**ED Visits/PTMPY:**~~
  - ~~**SPD:** Goal was met for all four quarters of the reporting data.~~
  - ~~**TANF ≤ 18:** Goal was met for all quarters except Q1 2020 2021 with a .69% increase above goal threshold.~~
- ~~**TANF > 18: Goal was not met in Q4 2019 and Q1 2020 2021 but fell within desired threshold for Q2 and Q3 20202021.**~~ All three subpopulations ~~met the~~are below goal through second quarter 2021, with an uptick noted for during third quarter and TANF > 18 above the goal~~for all four quarters of the time period.~~.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2019 To: September 2020

		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.5	5.0	7.1	7.2
	Bed Days PTMPY	1,062	972	1,095	1,230
	Pcnt Re-Admits	22%	22%	23%	23%
	ED Visits PTMPY	625	603	419	500
TANF > 18	ALOS	4.4	4.3	5.7	5.6
	Bed Days PTMPY	297	271	307	337
	Pcnt Re-Admits	18%	17%	17%	17%
	ED Visits PTMPY	416	434	304	342
TANF <= 18	ALOS	4.0	3.5	3.3	4.6
	Bed Days PTMPY	70	64	34	48
	Pcnt Re-Admits	12%	8%	8%	8%
	ED Visits PTMPY	349	377	109	146

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	6.26	6.22	4.50	5.90
	Bed Days PTMPY	1185.96	1,108.51	745.06	1,138.37
	Pcnt Re-Admits	25.57%	19.80%	17.86%	16.55%
	ED Visits PTMPY	528.95	469.49	530.23	555.68
TANF > 18	ALOS	5.19	4.34	4.03	4.54
	Bed Days PTMPY	489.44	346.82	321.23	403.84
	Pcnt Re-Admits	11.45%	9.57%	10.57%	10.95%
	ED Visits PTMPY	399.18	354.52	397.45	438.36
TANF <= 18	ALOS	2.87	4.21	3.22	2.84
	Bed Days PTMPY	22.03	33.12	28.83	26.12
	Pcnt Re-Admits	1.16%	1.02%	2.78%	3.87%
	ED Visits PTMPY	150.58	140.75	205.41	256.54

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2020 To: September 2021

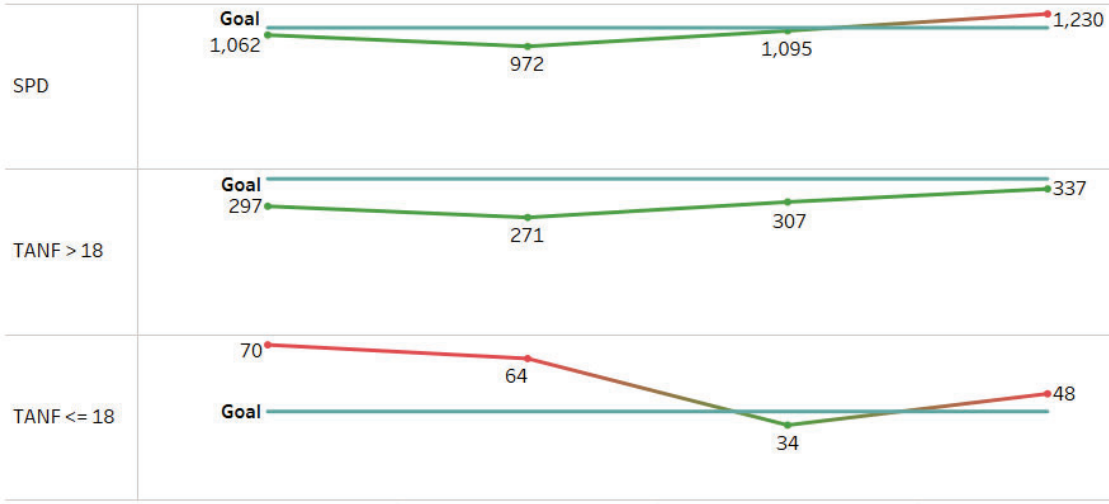
		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	6.6	6.4	4.6	4.7
	Bed Days PTMPY	1,195	1,047	694	569
	Pcnt Re-Admits	25%	20%	23%	22%
	ED Visits PTMPY	448	390	434	385
TANF > 18	ALOS	5.4	5.1	4.5	4.2
	Bed Days PTMPY	311	257	234	152
	Pcnt Re-Admits	17%	16%	18%	16%
	ED Visits PTMPY	310	265	295	256
TANF <= 18	ALOS	3.6	3.6	3.6	3.0
	Bed Days PTMPY	35	34	44	222
	Pcnt Re-Admits	10%	7%	5%	1%
	ED Visits PTMPY	134	124	180	185

Bed Days PTPMY

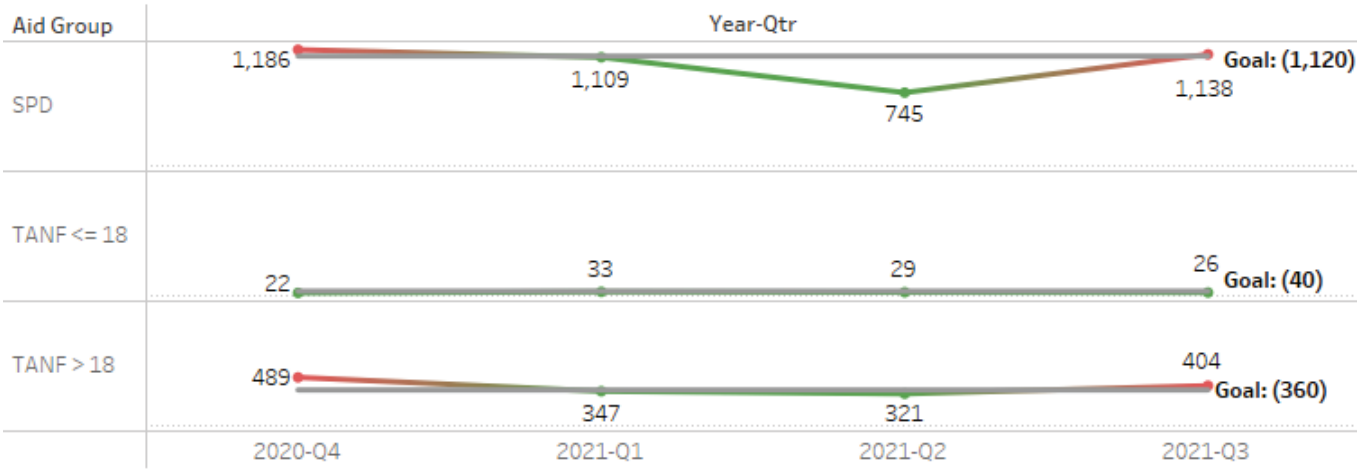
Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,062	1,120	▼	972	1,120	▼	1,095	1,120	▼	1,230	1,120	▲
TANF > 18	297	360	▼	271	360	▼	307	360	▼	337	360	▼
TANF <= 18	70	40	▲	64	40	▲	34	40	▼	48	40	▲



IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,120	1,186 ▲	1,109 ▼	745 ▼	1,138 ▲
TANF <= 18	40	22 ▼	33 ▼	29 ▼	26 ▼
TANF > 18	360	489 ▲	347 ▼	321 ▼	404 ▲

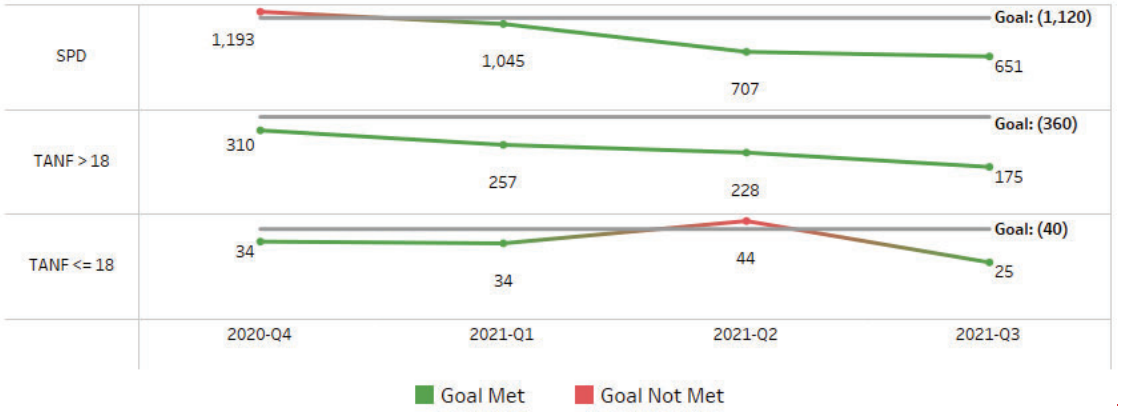
Legend: Goal Met, Not Met

Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2020 To: September 2021

	2020-Q4			2021-Q1			2021-Q2			2021-Q3		
	Bed Day..	Avg. Goal	Goal Va..	Bed Day..	Avg. Goal	Goal Va..	Bed Da..	Avg. Goal	Goal Va..	Bed Day..	Avg. Goal	Goal Va..
SPD	1,193	1,120	▲	1,045	1,120	▼	707	1,120	▼	651	1,120	▼
TANF > 18	310	360	▼	257	360	▼	228	360	▼	175	360	▼
TANF <= 18	34	40	▼	34	40	▼	44	40	▲	25	40	▼

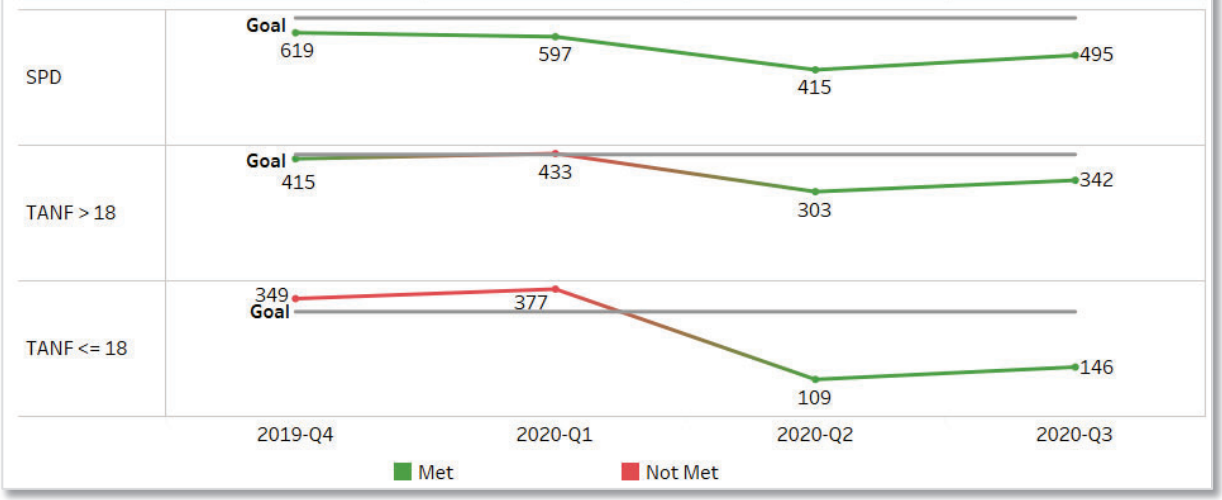


ED Visits PTPMY

Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance
SPD	619	700	▼	597	700	▼	415	700	▼	495	700	▼
TANF > 18	415	430	▼	433	430	▲	303	430	▼	342	430	▼
TANF <= 18	349	310	▲	377	310	▲	109	310	▼	146	310	▼

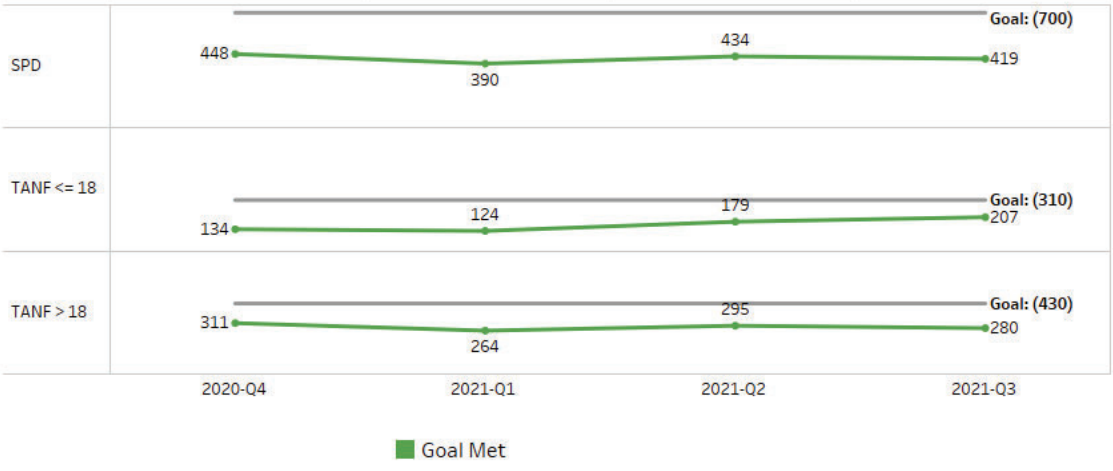


ED Visits PTPMY

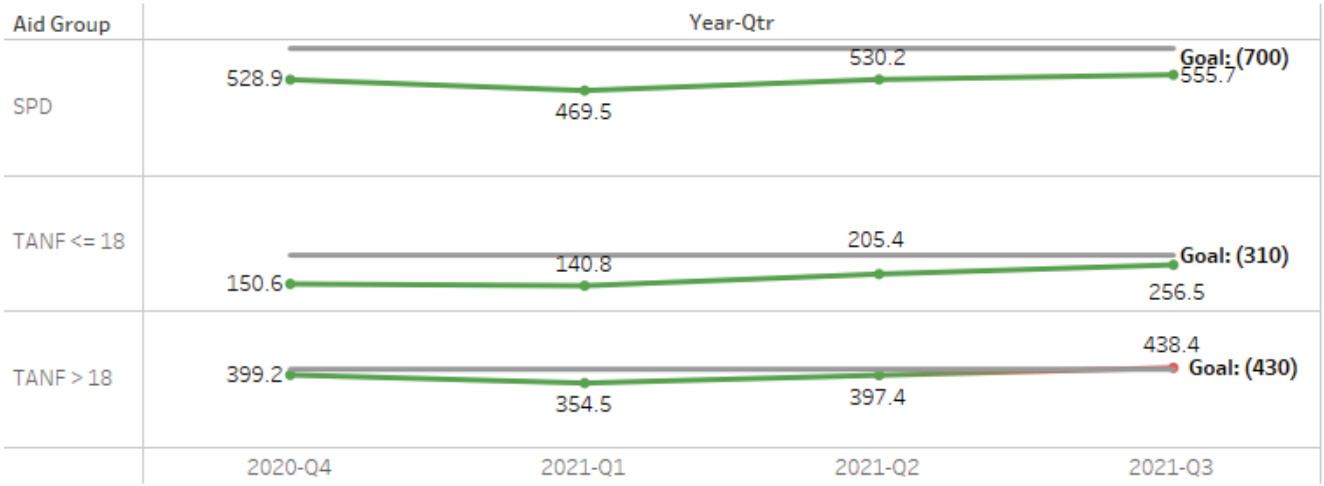
Line of Business: Medi-Cal Risk Group: Shared Risk - MC

From: October 2020 To: September 2021

	2020-Q4			2021-Q1			2021-Q2			2021-Q3		
	ED Visits PTMPY	Avg. Goal	Goal Variance	ED Visits PTMPY	Avg. Goal	Goal Variance	ED Visits PTMPY	Avg. Goal	Goal Variance	ED Visits PTMPY	Avg. Goal	Goal Variance
SPD	448	700	▼	390	700	▼	434	700	▼	419	700	▼
TANF <= 18	134	310	▼	124	310	▼	179	310	▼	207	310	▼
TANF > 18	311	430	▼	264	430	▼	295	430	▼	280	430	▼



ED Goal Analysis



		Measure / Year-Qtr ED Visits PTMPY			
Aid Group	Goal	2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	700	528.9 ▼	469.5 ▼	530.2 ▼	555.7 ▼
TANF <= 18	310	150.6 ▼	140.8 ▼	205.4 ▼	256.5 ▼
TANF > 18	430	399.2 ▼	354.5 ▼	397.4 ▼	438.4 ▲

Legend: Goal Met, Not Met

Medi-Cal CCN

- **Average Length of Stay**
  - **SPD**: Decrease noted in quarter two 2021 from previous two quarters, however, increase in ALOS during third quarter 2021. ~~**and**~~
  - ~~**T**~~**TANF <=> 18:** ~~Stable~~ Decreases ~~from~~or Q4 2019 and through Q1 Q2 2020~~2021~~, ~~increases for Q2 and Q3 2021~~both with upticks in Q4 2021.Steady quarter-over-quarter uptick from fourth quarter 2020 through third quarter 2021.
  - **TANF <= > 18:** ~~Trended upward for the first three quarters of the reporting period and dips slightly in Q3~~downward for all four quarters of the ~~2020~~2021data, ~~starting at 5.7 in Q4 2019 and finishing at 2.0 in Q3 2021.~~Uptick noted during second and third quarter 2021 with a decrease noted in third quarter.~~.~~
- **Bed Days/PTMPY:** SPD bed days demonstrated a decrease during second quarter 2021 and a slight uptick in third quarter 2021, but remained below the established goal of 1,830/K. TANF ≤ 18 was below goal during fourth quarter 202 and second quarter 2021 but was above the established goal of 100/K during first and third quarter 2021. ~~were consistently above the goal threshold for all four quarters by an average of approximately 7.4%. TANF subpopulations consistently met the goal for all four quarters.~~above or did not meet the goal, in Q1 2019, ~~otherwise all three subpopulations met the goal for the reporting period~~TANF > 18 was consistently about the goal of 710/k throughout the four measurement ~~.~~quarters.
- **Readmissions:** ~~SPD readmissions increased for the first three quarters of the reporting period and decreased by 5 percentage points in Q3 2020~~2021~~were stable for all four quarters of the data, hovering between 23% and 27%. TANF >18 readmissions were stable for first three quarters of the data then dropped sharply in Q3 2021~~were mildly volatile during this period, ~~decreasing in Q4 2019 and Q2 2020~~2021~~, increasing in Q1 and Q3 2020~~2021~~ from 23% to 5%. TANF ≤ 18 subpopulation was pretty volatile, increased from~~started out at only 1% in Q4 2019~~, through Q2 2021 and~~and then ~~dropped by 15~~increasing to ~~percentage points in Q3 2020~~2021~~between 10% and 25%.~~All three subpopulations showed a decrease in readmissions throughout the measurement period. It is noted that the TANF ≤ 18 did not have any members readmitted during fourth quarter 2020 and second quarter 2021.
- ~~**ED Visits/PTMPY**~~
  - ~~**SPD:** Goal was not met in Q4 2019 and Q1 2020~~2021~~, met goal for remaining quarters.~~
  - ~~**TANF > 18:** Goal was not met in Q4 2019 and Q1 2020~~2021~~, met goal for remaining quarters.~~
- ~~**TANF ≤ 18: Goal was met for all four quarters**~~: ~~All su~~bpopulations ~~met their respective goals for all four quarters of the data.~~.~~~~
- Both the SPD and TANF > 18 were above goal throughout the measurement period, however TANF ≤ remained below goal, demonstrated a quarter-over-quarter increase.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	6.68	6.65	5.54	6.17
	Bed Days PTMPY	1959.67	1,697.13	1,517.72	1,723.88
	Pcnt Re-Admits	21.98%	20.09%	17.93%	17.77%
	ED Visits PTMPY	733.13	813.85	899.86	837.39
TANF > 18	ALOS	4.25	5.44	5.82	4.92
	Bed Days PTMPY	899.12	975.46	1123.37	932.70
	Pcnt Re-Admits	7.72%	7.84%	8.10%	7.24%
	ED Visits PTMPY	559.53	639.03	769.01	647.59
TANF <= 18	ALOS	4.66	4.95	5.44	5.93
	Bed Days PTMPY	83.62	111.90	94.26	115.51
	Pcnt Re-Admits	0.00%	4.03%	0.00%	6.43%
	ED Visits PTMPY	203.17	209.57	288.90	346.19

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2020 To: September 2021

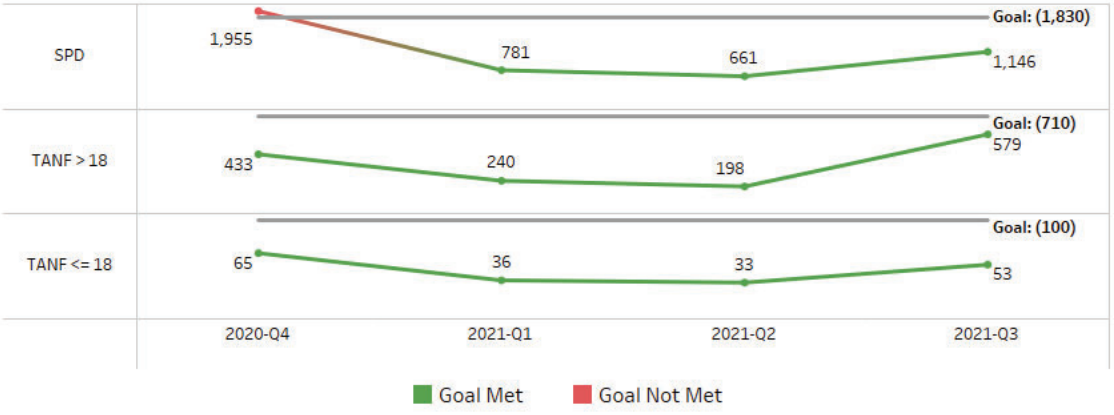
		2020-Q4	2021-Q1	2021-Q2	2021-Q3
a.SPD	ALOS	7.1	3.3	2.6	5.8
	Bed Days PTMPY	1,955	781	661	1,146
	Pcnt Re-Admits	27%	26%	23%	25%
	ED Visits PTMPY	578	515	546	504
b.TANF > 18	ALOS	5.7	3.1	2.5	2.0
	Bed Days PTMPY	433	240	198	579
	Pcnt Re-Admits	21%	21%	23%	5%
	ED Visits PTMPY	418	375	432	384
c.TANF <= 18	ALOS	5.0	2.6	2.5	4.3
	Bed Days PTMPY	65	36	33	53
	Pcnt Re-Admits	1%	17%	10%	25%
	ED Visits PTMPY	175	155	212	262

Bed Days PTPMY

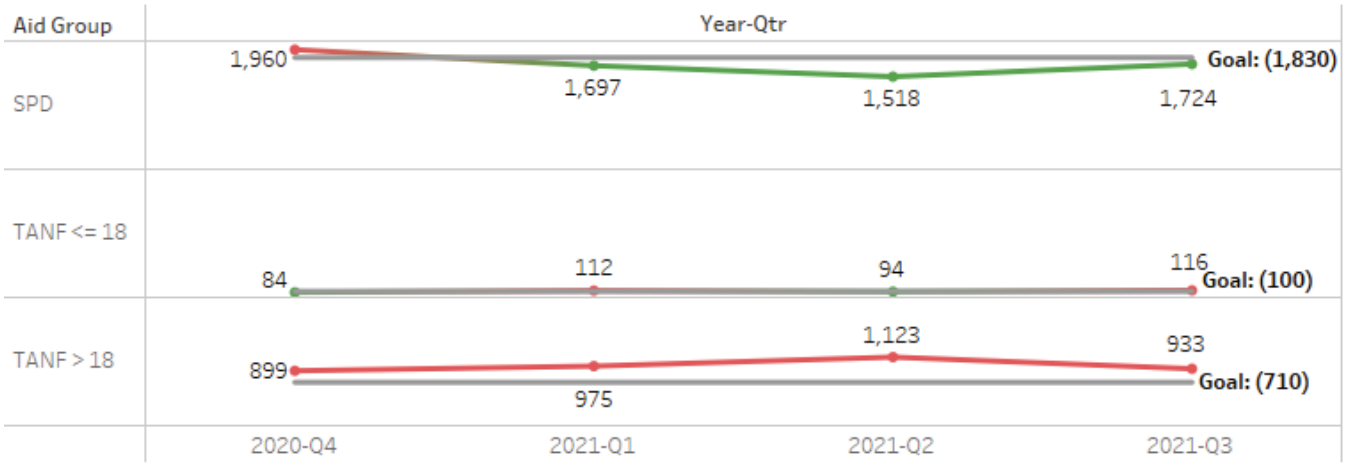
Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2020 To: September 2021

	2020-Q4			2021-Q1			2021-Q2			2021-Q3		
	Bed Day..	Avg. Goal	Goal Va..	Bed Day..	Avg. Goal	Goal Va..	Bed Da..	Avg. Goal	Goal Va..	Bed Day..	Avg. Goal	Goal Va..
SPD	1,955	1,830	▲	781	1,830	▼	661	1,830	▼	1,146	1,830	▼
TANF > 18	433	710	▼	240	710	▼	198	710	▼	579	710	▼
TANF <= 18	65	100	▼	36	100	▼	33	100	▼	53	100	▼



IP Goal Analysis



		Measure / Year-Qtr			
		Bed Days PTMPY			
Aid Group	Goal	2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,830	1,960 ▲	1,697 ▼	1,518 ▼	1,724 ▼
TANF <= 18	100	84 ▼	112 ▲	94 ▼	116 ▲
TANF > 18	710	899 ▲	975 ▲	1,123 ▲	933 ▲

Legend: Goal Met, Not Met

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2019 To: September 2020

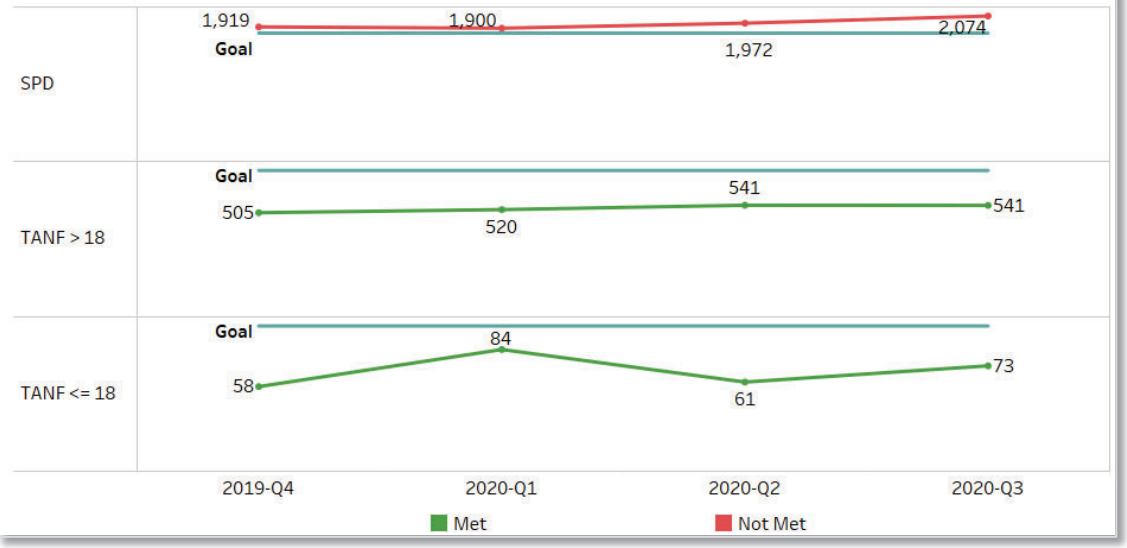
		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.6	5.8	7.7	7.2
	Bed Days PTMPY	1,919	1,900	1,972	2,074
	Pcnt Re-Admits	31%	34%	35%	30%
	ED Visits PTMPY	827	874	484	582
TANF > 18	ALOS	5.5	5.5	6.6	6.5
	Bed Days PTMPY	505	520	541	541
	Pcnt Re-Admits	26%	28%	25%	30%
	ED Visits PTMPY	589	582	382	448
TANF <= 18	ALOS	3.3	4.4	5.6	5.5
	Bed Days PTMPY	58	84	61	73
	Pcnt Re-Admits	9%	13%	21%	6%
	ED Visits PTMPY	444	453	131	183

Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,919	1,830	▲	1,900	1,830	▲	1,972	1,830	▲	2,074	1,830	▲
TANF > 18	505	710	▼	520	710	▼	541	710	▼	541	710	▼
TANF <= 18	58	100	▼	84	100	▼	61	100	▼	73	100	▼

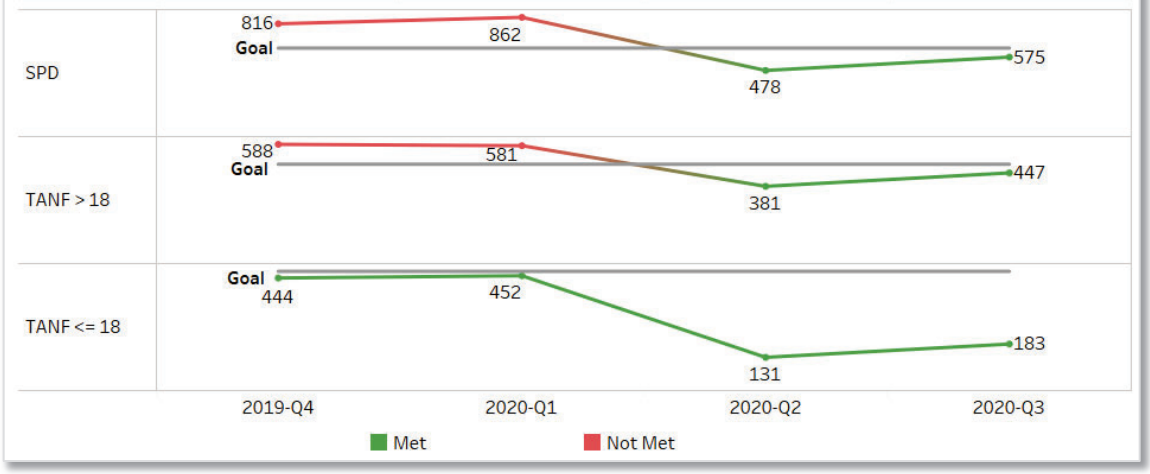


ED Visits PTPMY

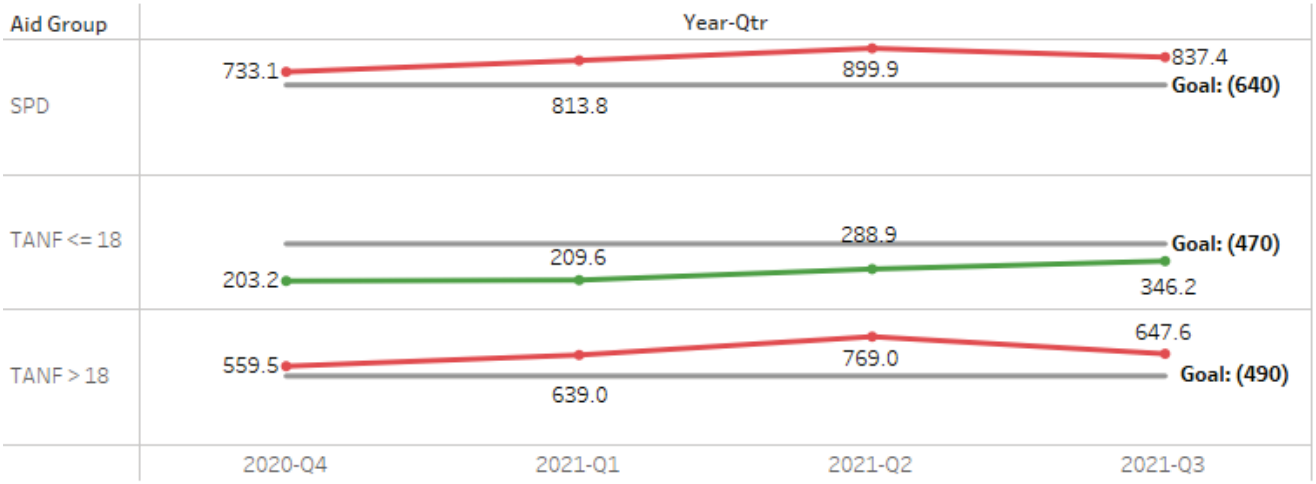
Line of Business: Medi-Cal Risk Group: CCN - MC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance
SPD	816	640	▲	862	640	▲	478	640	▼	575	640	▼
TANF > 18	588	490	▲	581	490	▲	381	490	▼	447	490	▼
TANF <= 18	444	470	▼	452	470	▼	131	470	▼	183	470	▼

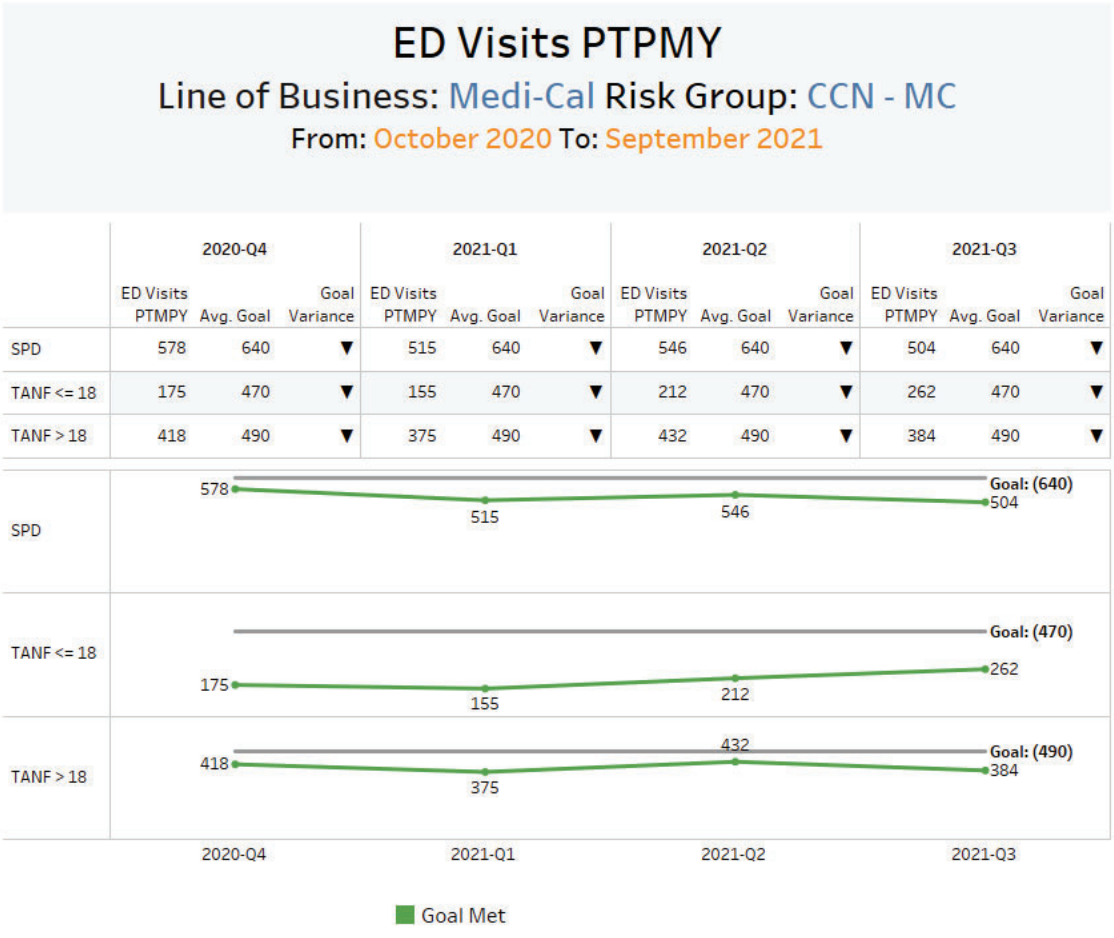


ED Goal Analysis



		Measure / Year-Qtr ED Visits PTMPY			
Aid Group	Goal	2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	640	733.1 ▲	813.8 ▲	899.9 ▲	837.4 ▲
TANF <= 18	470	203.2 ▼	209.6 ▼	288.9 ▼	346.2 ▼
TANF > 18	490	559.5 ▲	639.0 ▲	769.0 ▲	647.6 ▲

Legend: Goal Met, Not Met



CalOptima Direct Administrative (CODA)

- **Average Length of Stay:**
  - **SPD:** Consistently increases through Q4 2019 and Q2 20202021, dips slightly in Q3.
  - **TANF >18/ TANF≤18:** Increases consistently over the four quarters reported All three subpopulations trended downward for the first three quarters of the data with upticks in Q3 2021. For the SPD and TANF > 18 subpopulations, ALOS trended down from fourth quarter 2020 through second quarter 2021, then significantly increased during third quarter 2021. The TANF ≤ 18 subpopulation spiked from fourth quarter 2020 to first quarter 2021, then shoed a decrease in ALOS in second and third quarter.
- **Bed Days/PTMPY:** Both SPD and TANF ≤ >18 was consistently within did not meet the goal,; however, although SPD did meet during first quarter 2021. SPD did not meetmeet the goal foinr Q3 20202021. TANF ≤> 18 did not meet the goal for all four quarters reported.Q4 2019fourth quarter 2020 and third quarter 2021, but did reach the goal, but consistently met the goal for the first three quarters of 2021.did meet first and second quarter goals in 2021.
- **Readmissions:** SPD and TANF ≤18TANF subpopulations trend increase slightly between Q4 2019 and Q1 2020 2021 and subsequently decrease sharply through Q3 20202021downward for all four quarters of the data with one slight uptick in Q1 2021 for the TANF ≤ 18 population. TANF >18 remained a little more stable, hovering between 10 and 18%SPD was a little volatile for the first three quarters of the data and falling to 0% in Q3 2021.SPD readmissions did reveal a downward trend for all four quarters during the measurement period. TANF > 18 and ≤ 18 did show a downward trend, but both subpopulations demonstrated an increase in readmissions during third quarter

2021.

- **ED Visits/PTPMY:** ~~No SPD~~Not enough ~~data for~~ to identify any trends for ED visits, both ~~TANF subpopulations met the goal for all four quarters.~~.Both SPD and TANF ≤ 18 were consistently below goal during the period. TANF > 18 was above goal, with a significant spike in second quarter, which decreased in third quarter, but was above goal.

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	8.70	5.04	7.11	10.28
	Bed Days PTMPY	2397.96	1,332.77	2,342.36	2,299.78
	Pcnt Re-Admits	36.11%	27.35%	23.38%	12.43%
	ED Visits PTMPY	673.47	1047.90	869.23	796.42
TANF > 18	ALOS	6.07	4.06	4.73	6.01
	Bed Days PTMPY	875.27	488.04	647.64	1178.87
	Pcnt Re-Admits	9.38%	7.68%	0.00%	13.33%
	ED Visits PTMPY	412.90	476.69	2509.32	574.49
TANF <= 18	ALOS	7.95	9.15	7.98	5.39
	Bed Days PTMPY	347.02	316.51	362.58	182.19
	Pcnt Re-Admits	13.18%	11.47%	2.96%	10.61%
	ED Visits PTMPY	218.15	154.73	267.96	371.89

Utilization Outcomes

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2019 To: September 2020

		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	6.2	7.4	10.7	9.5
	Bed Days PTMPY	1,528	1,910	1,691	2,430
	Pcnt Re-Admits	23%	26%	14%	4%
	ED Visits PTMPY				
TANF > 18	ALOS	5.0	5.8	6.1	7.6
	Bed Days PTMPY	390	315	340	460
	Pcnt Re-Admits	17%	13%	18%	10%
	ED Visits PTMPY	7	1		1
TANF <= 18	ALOS	8.8	9.5	12.5	12.4
	Bed Days PTMPY	441	505	503	574
	Pcnt Re-Admits	6%	8%	3%	0%
	ED Visits PTMPY	13		1	

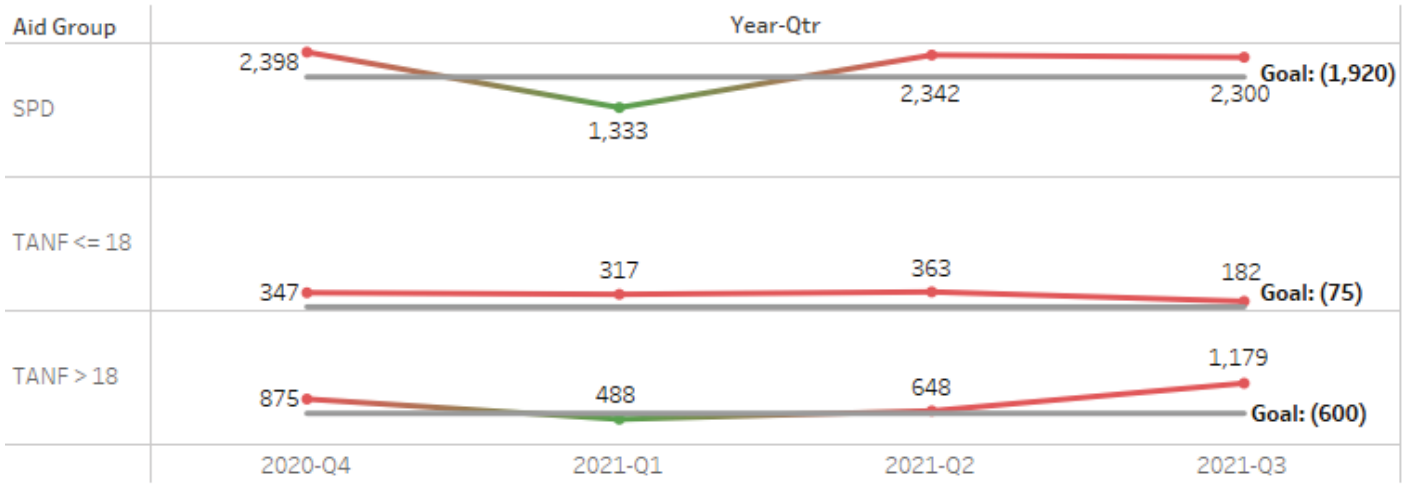
Utilization Outcomes

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	10.7	5.5	4.9	7.5
	Bed Days PTMPY	3,356	1,999	2,100	1,418
	Pcnt Re-Admits	22%	19%	29%	0%
	ED Visits PTMPY				
TANF > 18	ALOS	5.7	3.9	4.3	5.4
	Bed Days PTMPY	707	374	454	578
	Pcnt Re-Admits	13%	12%	9%	9%
	ED Visits PTMPY	1		2	
TANF <= 18	ALOS	8.3	8.2	2.1	4.6
	Bed Days PTMPY	662	549	148	203
	Pcnt Re-Admits	5%	8%	4%	3%
	ED Visits PTMPY				4

IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,920	2,398 ▲	1,333 ▼	2,342 ▲	2,300 ▲
TANF <= 18	75	347 ▲	317 ▲	363 ▲	182 ▲
TANF > 18	600	875 ▲	488 ▼	648 ▲	1,179 ▲

Legend: Goal Met, Not Met

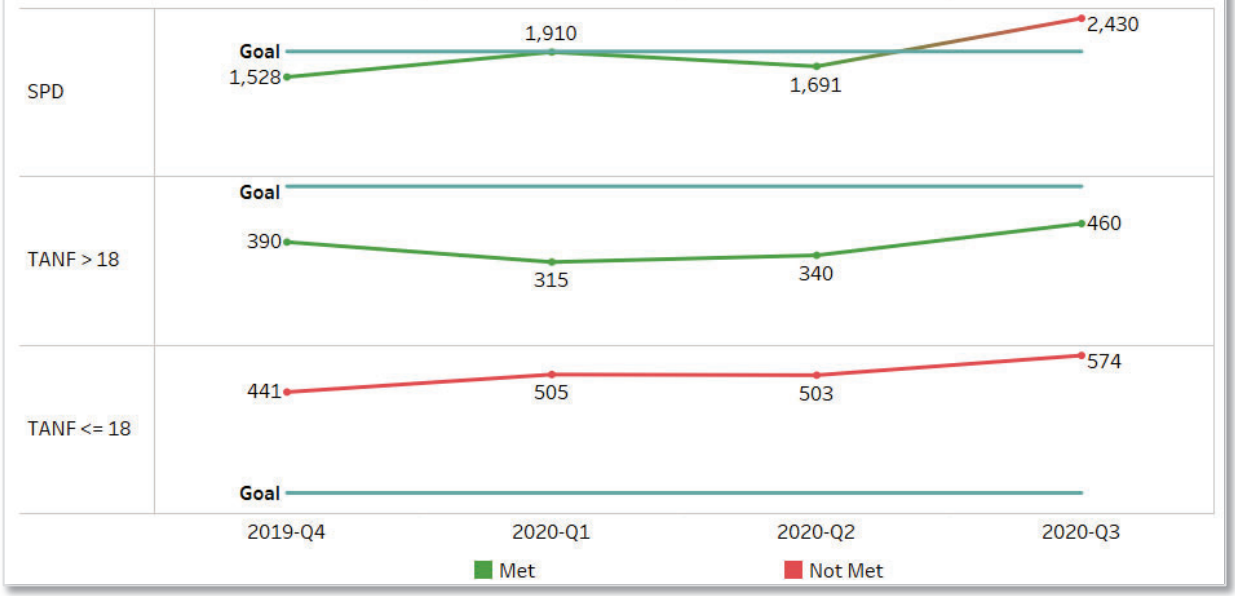
Back To Item Back to Agenda

Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,528	1,920	▼	1,910	1,920	▼	1,691	1,920	▼	2,430	1,920	▲
TANF > 18	390	600	▼	315	600	▼	340	600	▼	460	600	▼
TANF <= 18	441	75	▲	505	75	▲	503	75	▲	574	75	▲

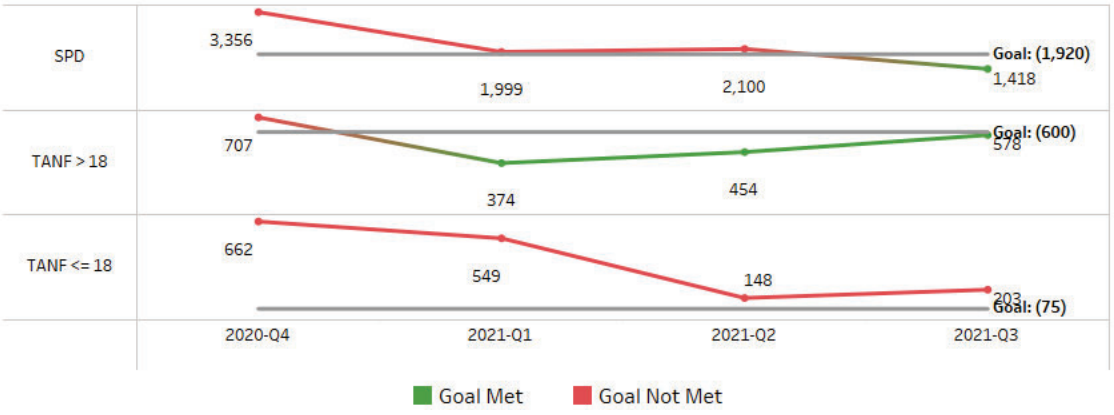


Bed Days PTPMY

Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2020 To: September 2021

	2020-Q4			2021-Q1			2021-Q2			2021-Q3		
	Bed Day..	Avg. Goal	Goal Va..	Bed Day..	Avg. Goal	Goal Va..	Bed Da..	Avg. Goal	Goal Va..	Bed Day..	Avg. Goal	Goal Va..
SPD	3,356	1,920	▲	1,999	1,920	▲	2,100	1,920	▲	1,418	1,920	▼
TANF > 18	707	600	▲	374	600	▼	454	600	▼	578	600	▼
TANF <= 18	662	75	▲	549	75	▲	148	75	▲	203	75	▲

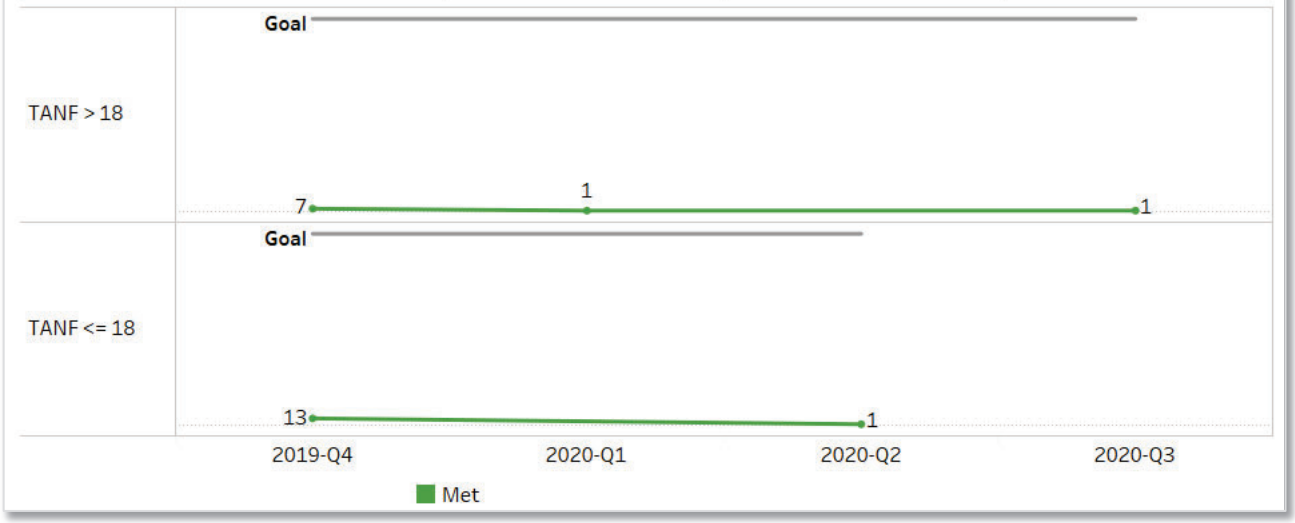


ED Visits PTPMY

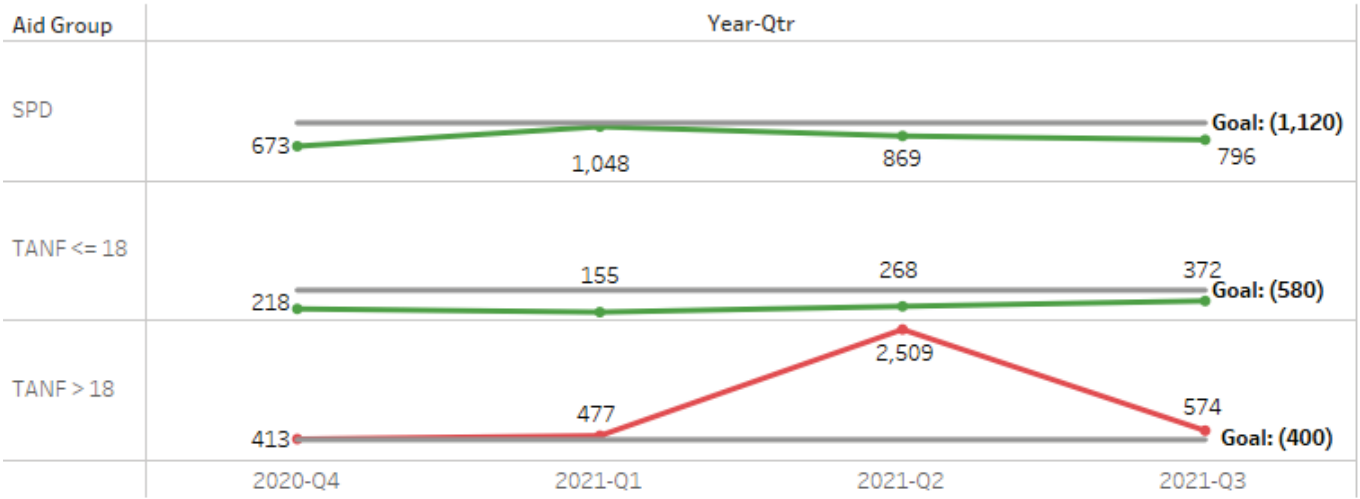
Line of Business: Medi-Cal Risk Group: COD Admin

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance
TANF > 18	7	580	▼	1	580	▼				1	580	▼
TANF <= 18	13	400	▼				1	400	▼			

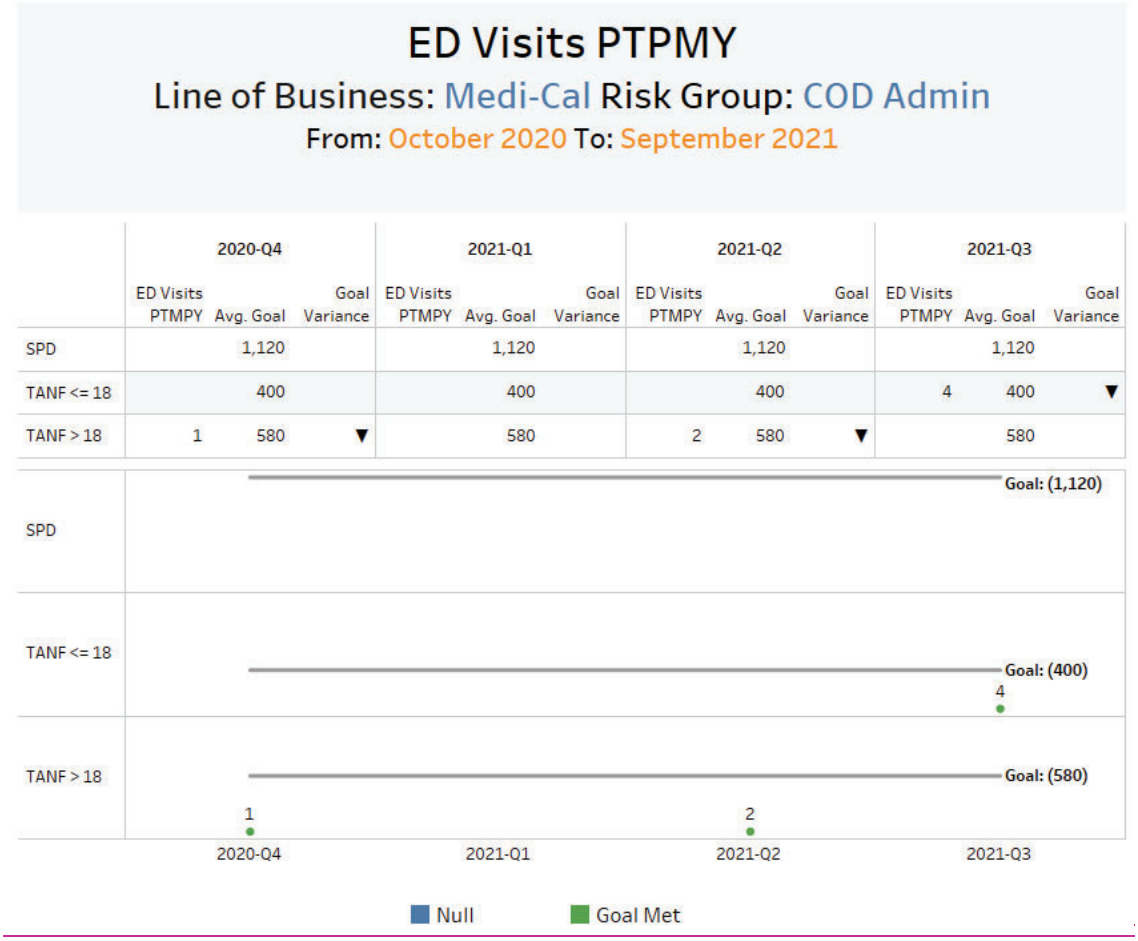


ED Goal Analysis



		Measure / Year-Qtr ED Visits PTMPY			
Aid Group	Goal	2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,120	673 ▼	1,048 ▼	869 ▼	796 ▼
TANF <= 18	580	218 ▼	155 ▼	268 ▼	372 ▼
TANF > 18	400	413 ▲	477 ▲	2,509 ▲	574 ▲

Legend: Goal Met, Not Met



OneCare Connect Shared Risk

- ~~**Average Length of Stay:**~~
  - ~~SPD: Consistent from Q4 2019 through Q1 20202021, rose slightly in Q2 and Q3 2021.~~
- ~~TANF >18: Fluctuated between Q4 2019 and Q2 2020~~ 2021 ~~by about 1.1 average days.~~ SPD ALOS trends downward for first three quarters of the data with an uptick in Q3 2021. TANF > 18 also trends downward with only a sharp uptick in Q1 2021.ALOS showed a steady decline throughout the measurement period, with a slight uptick for SPD during third quarter 2021.
- **Bed Days/PTMPY:** SPD ~~group did not meet~~met ~~the goal in Q4 2019 and Q3 2021for the whole time period~~subpopulation was slightly above goal during fourth quarter 202 and met goal for the remaining three quarters of the measurement period. ~~but met the goal for the remaining quarters. There is not established goal for the TANF >18 group, however we do see a sharp increase in volume of 457% between Q4 2019 and Q1 2021 and then a 48% decrease in Q3 20202021.~~No established goal for the TANF > 18, however bed days ~~trend downward with a huge upswing in Q1 2021.~~did reveal a significant uptick in second quarter 2021.
- **Readmissions:** ~~SPD readmissions decrease by about 1% quarter-over-quarter. The TANF group increases by 9% in Q1 2021 and then sharply by 42% in Q2 20202021.~~Both SPD and TANF show volatile readmission rates for all four quarters with the TANF group jumping rapidly to 75% in Q3 2021.
- **ED Visits/PTMPY:** SPD ED visits consistently met the goal for all four quarters. The TANF >18 group does not have an established goal but ~~remained consistent for all four~~

~~quarters.~~did demonstrate a significant spike in ED use during second quarter 2021 and then fell to its lowest level in third quarter.

Utilization Outcomes

Line of Business: OCC Risk Group: Shared Risk - OCC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.16	6.51	5.29	5.73
	Bed Days PTMPY	1413.65	1,235.19	956.08	1,083.16
	Pcnt Re-Admits	16.14%	17.22%	5.88%	8.61%
	ED Visits PTMPY	298.19	286.83	330.83	359.43
TANF > 18	ALOS	8.00	15.85	4.00	2.60
	Bed Days PTMPY	2614.79	8078.43	1674.42	423.91
	Pcnt Re-Admits	42.86%	10.26%	16.67%	0.00%
	ED Visits PTMPY	560.31	588.24	2442.48	391.30

~~NOTE: For Q3 2020~~ 2021 ~~there are not any data for TANF >18 at this time, most likely due to immaturity of the data.~~

Utilization Outcomes

Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2019 To: September 2020

		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	5.9	5.9	7.3	7.1
	Bed Days PTMPY	1,451	1,206	1,296	1,523
	Pcnt Re-Admits	24%	23%	22%	20%
	ED Visits PTMPY	370	363	240	262
TANF > 18	ALOS	4.5	6.0	5.3	
	Bed Days PTMPY	431	2,402	1,249	
	Pcnt Re-Admits	50%	50%	100%	
	ED Visits PTMPY	334	478	403	

Utilization Outcomes

Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2020 To: September 2021

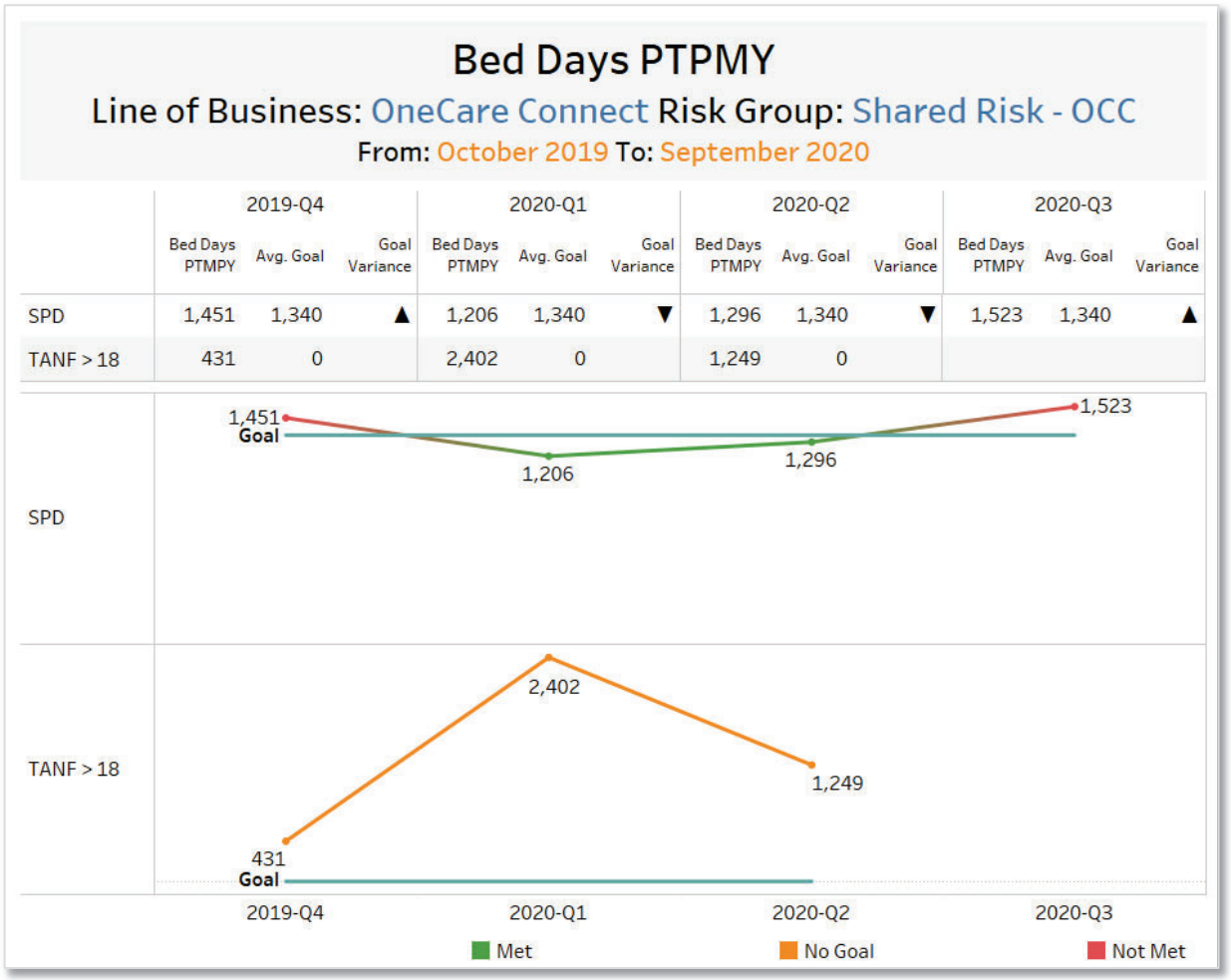
		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.2	6.2	5.4	6.1
	Bed Days PTMPY	1,320	1,183	973	804
	Pcnt Re-Admits	19%	16%	11%	12%
	ED Visits PTMPY	246	217	257	238
TANF > 18	ALOS	5.9	19.7	5.5	3.0
	Bed Days PTMPY	2,054	8,653	1,747	427
	Pcnt Re-Admits	14%	9%	11%	75%
	ED Visits PTMPY	428	483	470	314

Bed Days PTMPY

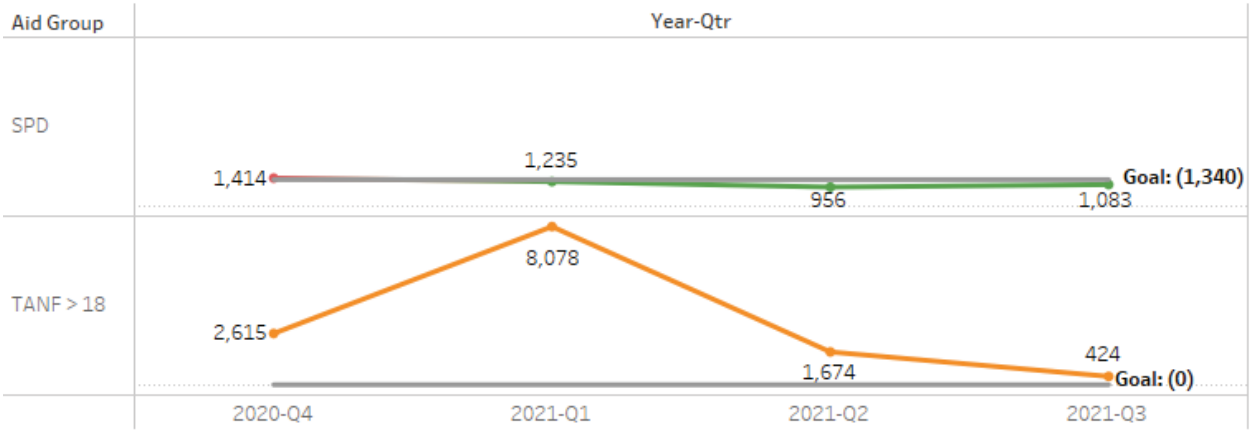
Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,451	1,340	▲	1,206	1,340	▼	1,296	1,340	▼	1,523	1,340	▲
TANF > 18	431	0		2,402	0		1,249	0				



IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,340	1,414 ▲	1,235 ▼	956 ▼	1,083 ▼
TANF > 18	0	2,615	8,078	1,674	424

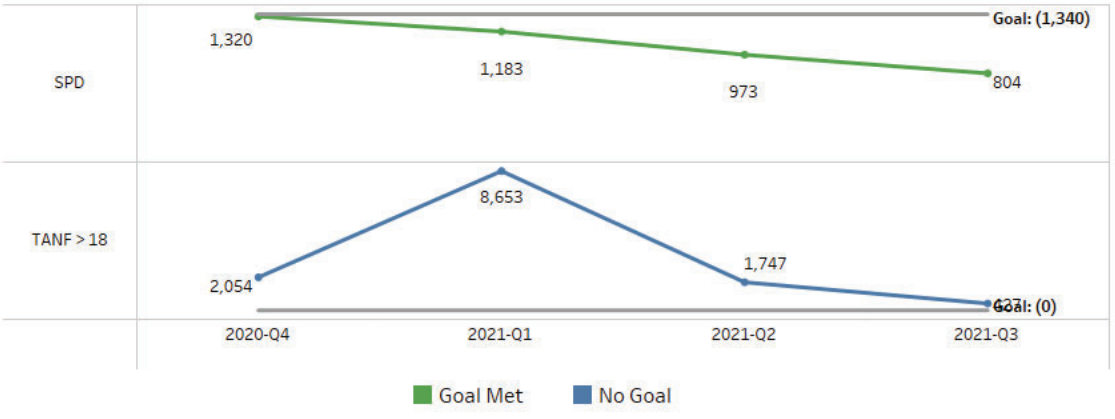
Legend: Goal Met | No Goal | Not Met

Bed Days PTPMY

Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2020 To: September 2021

	2020-Q4 Bed Days PTMPY	Avg. Goal	Goal Variance	2021-Q1 Bed Days PTMPY	Avg. Goal	Goal Variance	2021-Q2 Bed Days PTMPY	Avg. Goal	Goal Variance	2021-Q3 Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,320	1,340	▼	1,183	1,340	▼	973	1,340	▼	804	1,340	▼
TANF > 18	2,054	0		8,653	0		1,747	0		427	0	

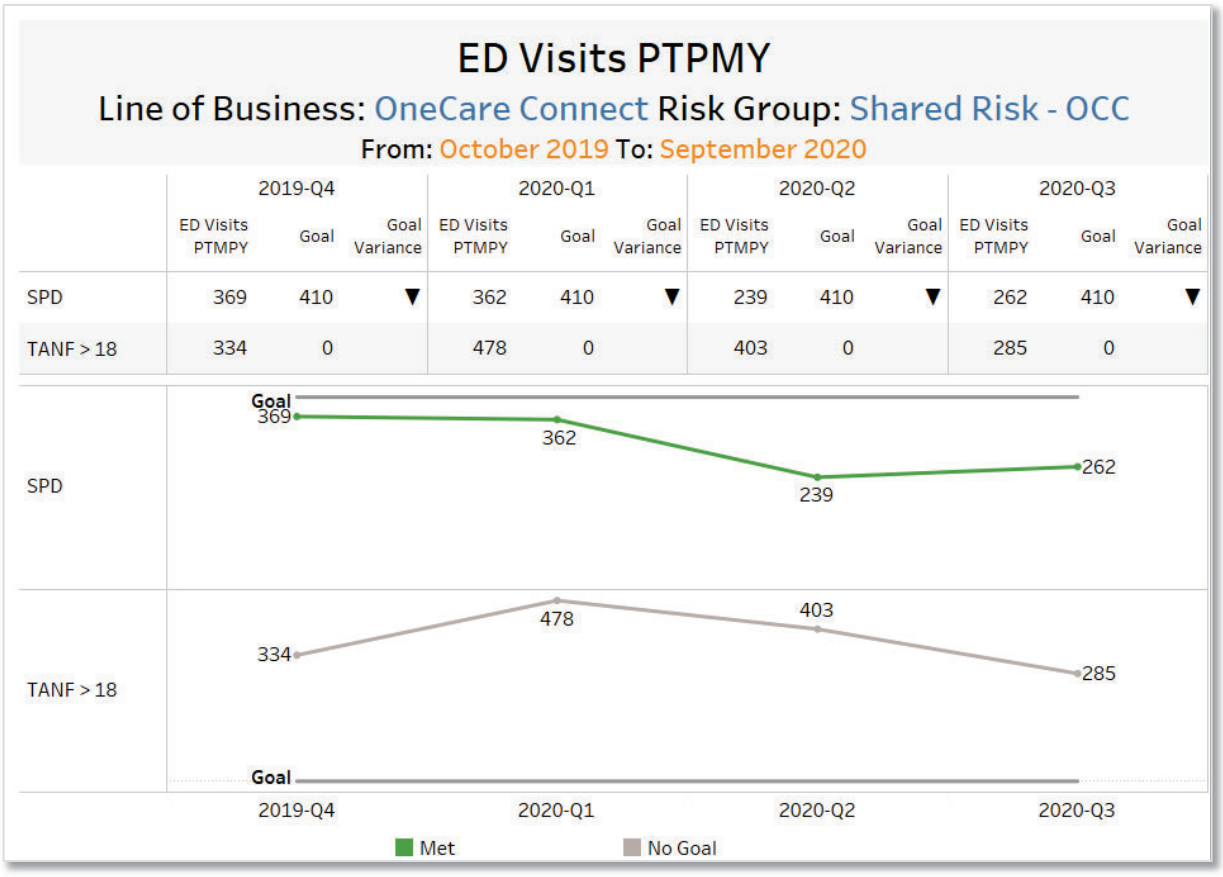


ED Visits PTPMY

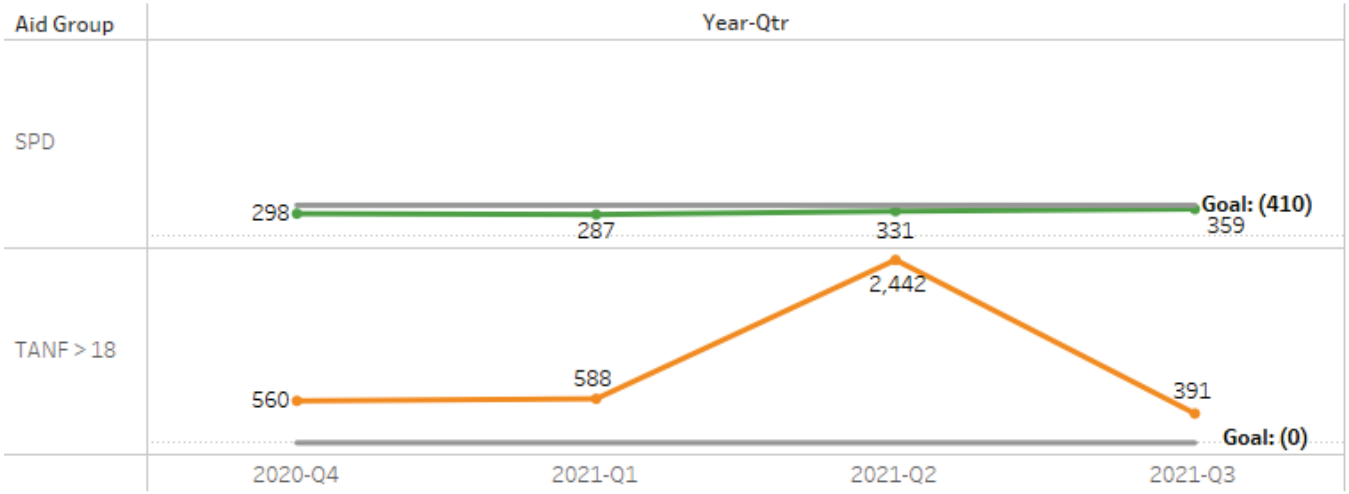
Line of Business: OneCare Connect Risk Group: Shared Risk - OCC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance
SPD	369	410	▼	362	410	▼	239	410	▼	262	410	▼
TANF > 18	334	0		478	0		403	0		285	0	

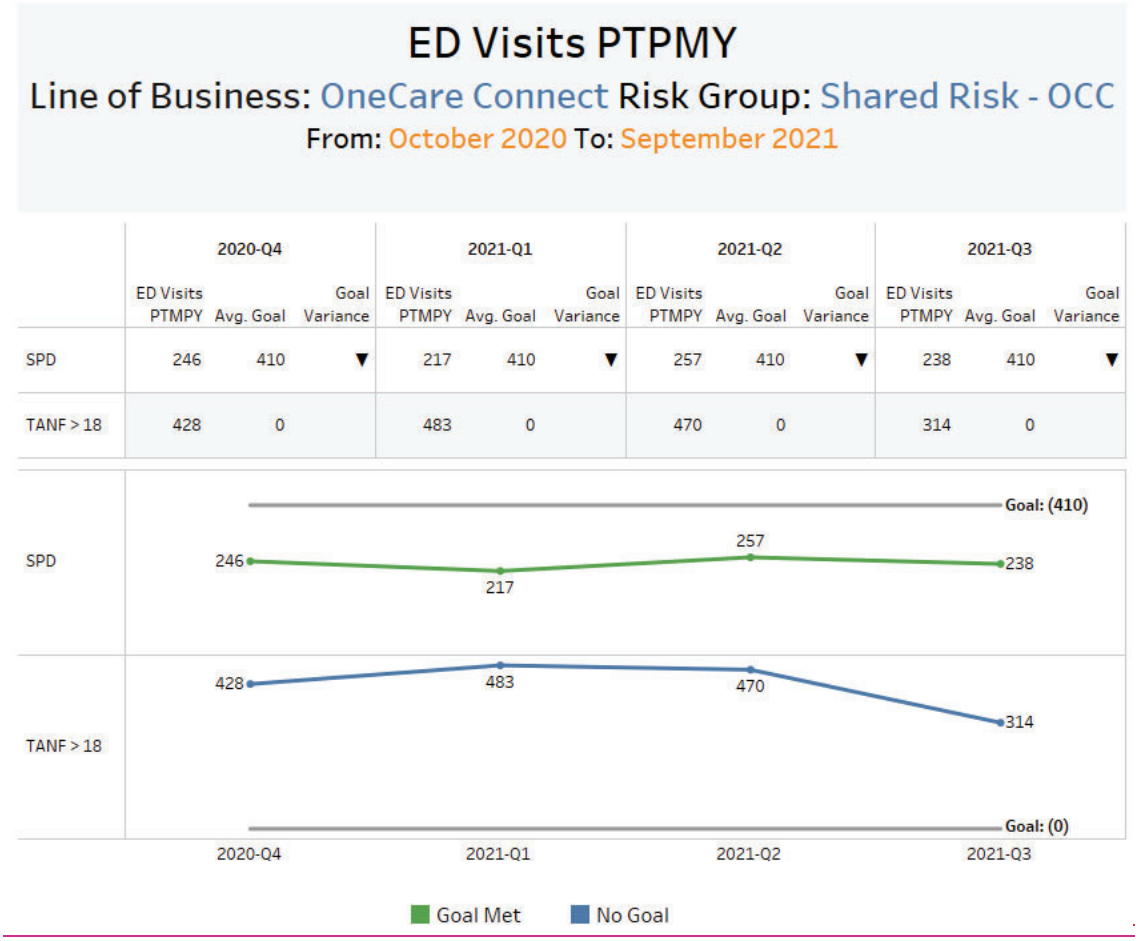


ED Goal Analysis



		Measure / Year-Qtr ED Visits PTMPY			
Aid Group	Goal	2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	410	298 ▼	287 ▼	331 ▼	359 ▼
TANF > 18	0	560	588	2,442	391

Legend: Goal Met, No Goal

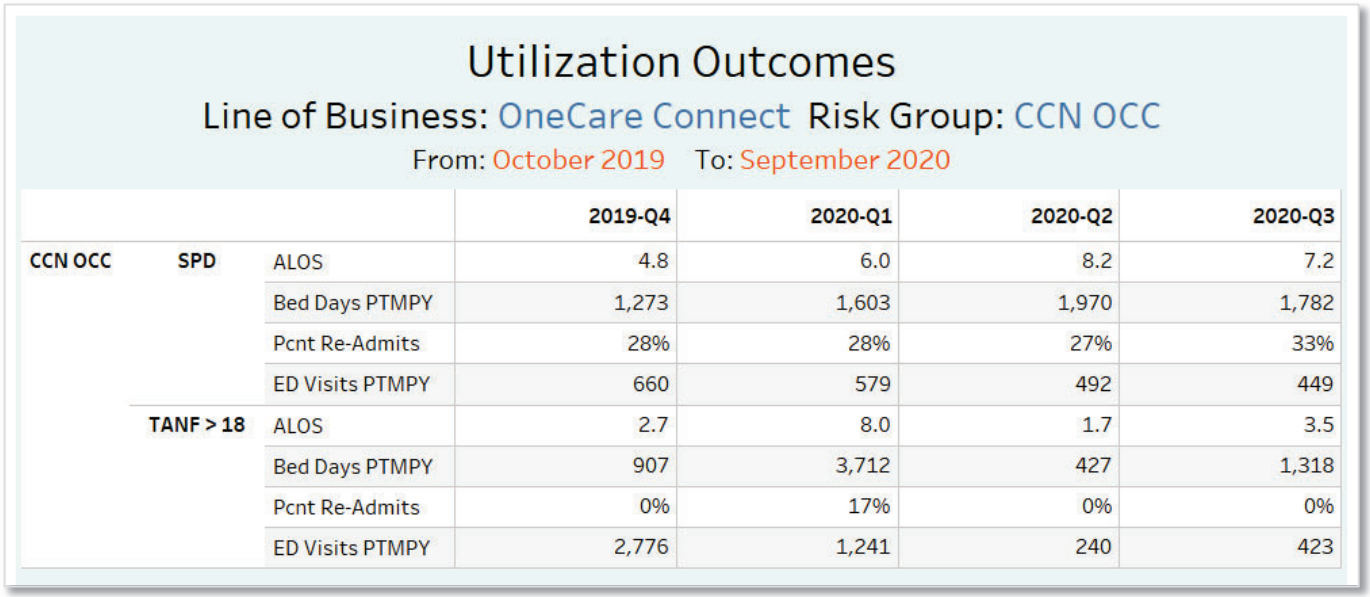


OneCare Connect CCN

- **Average Length of Stay:** ~~SPD Both populations increased during each of the first 3 quarters of the reporting period, with a decrease in Q3 20202021. The TANF >18 population was mildly volatile during the reporting period, spiking in Q1 20202021.trend downward for all four quarters of the data with a slight uptick in Q1 2021 for the TANF > 18.~~Both subpopulations demonstrated a downward trend in ALOS throughout the measurement period.
- **Bed Days/PTPMY:** SPD met the goal throughout the measurement period with a downward trend noted. TANF > 18 does not have an established goal, however there was a spike noted in first quarter 2021, which decreased in second quarter with a significant drop in third quarter 2021.~~The SPD group did not meet the goal in Q4 2021 but consistently met the goal in the subsequent quarters met the goal for all four quarters. . There is no established goal for the TANF >18 group, however, we do see volatility and a sharp increase of 309% in Q1 20202021The TANF > 18 group does not have an established goal but shows a huge increase in bed days for Q1 and Q2 of 2021..~~
- **Readmissions:** SPD ~~population remained stable during all four quarters, hovering between 27 and 33%.volatile between 14% and 29% for the time period. The TANF > 18 group readmissions only occurred in Q1 2020 2021 at 17%.trends upward for first three quarters of the data with a decrease in Q3 2021.~~demonstrated a downward trend in readmission rates throughout the measurement period. TANF > 18, however, did not have any readmissions noted from fourth quarter 2020 through second quarter

2021 and then demonstrated a significant spike in third quarter 2021.

- **ED Visits/PTPMY:** SPD ~~did not meet~~was consistently above goal throughout the measurement period, with TANF > 18 extremely variable throughout the measurement period trending downward from fourth quarter 2020 to second quarter 2020, with a significant spike in ED usage during third quarter 2021. ~~met the goal for all four quarters, trending downward. The TANF >18 population has no established goal but trended downward during the reporting period with a slight increase in Q3 Q2 20202021.~~



Utilization Outcomes

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2019 To: September 2020

			2019-Q4	2020-Q1	2020-Q2	2020-Q3
CCN OCC	SPD	ALOS	4.8	6.0	8.2	7.2
		Bed Days PTMPY	1,273	1,603	1,970	1,782
		Pcnt Re-Admits	28%	28%	27%	33%
		ED Visits PTMPY	660	579	492	449
	TANF > 18	ALOS	2.7	8.0	1.7	3.5
		Bed Days PTMPY	907	3,712	427	1,318
		Pcnt Re-Admits	0%	17%	0%	0%
		ED Visits PTMPY	2,776	1,241	240	423

Utilization Outcomes

Line of Business: OCC Risk Group: CCN OCC

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.10	6.08	5.54	5.43
	Bed Days PTMPY	1835.22	1,744.35	1,469.62	1,501.68
	Pcnt Re-Admits	16.84%	17.48%	13.17%	9.41%
	ED Visits PTMPY	501.23	456.24	468.58	512.72
TANF > 18	ALOS	28.00	14.73	9.56	5.09
	Bed Days PTMPY	6556.10	9000.00	8307.69	2788.38
	Pcnt Re-Admits	0.00%	0.00%	0.00%	27.27%
	ED Visits PTMPY	819.51	555.56	434.39	1145.23

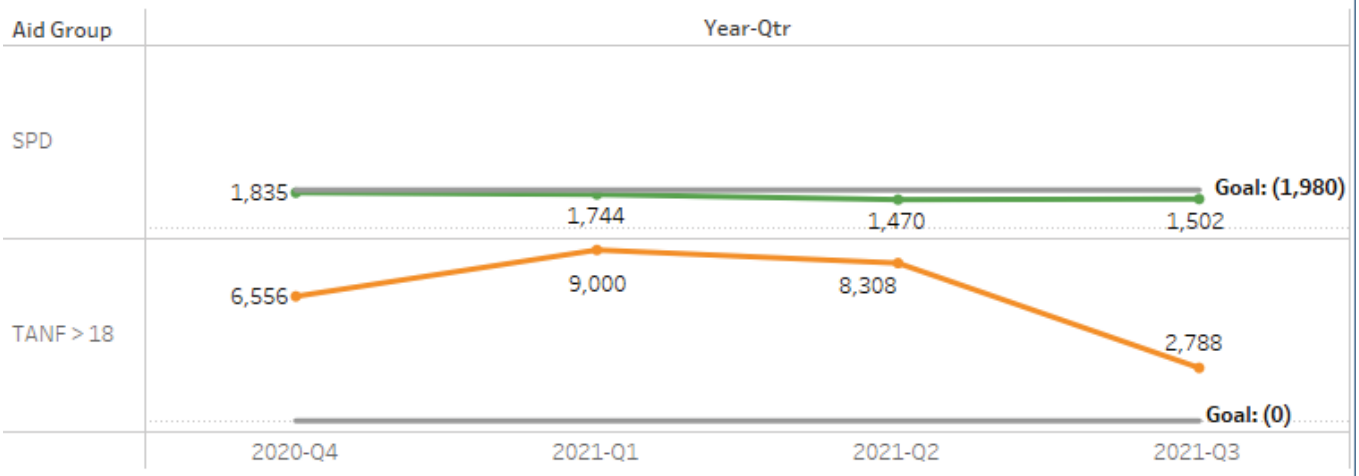
Utilization Outcomes

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2020 To: September 2021

			2020-Q4	2021-Q1	2021-Q2	2021-Q3
CCN OCC	SPD	ALOS	8.1	6.5	6.5	5.7
		Bed Days PTMPY	2,062	1,780	1,322	1,031
		Pcnt Re-Admits	20%	29%	28%	14%
		ED Visits PTMPY	391	348	344	305
	TANF > 18	ALOS	10.2	13.0	7.6	4.7
		Bed Days PTMPY	2,581	7,631	8,004	1,284
		Pcnt Re-Admits	0%	18%	32%	17%
		ED Visits PTMPY	529	339	398	265

IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr: Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,980	1,835 ▼	1,744 ▼	1,470 ▼	1,502 ▼
TANF > 18	0	6,556	9,000	8,308	2,788

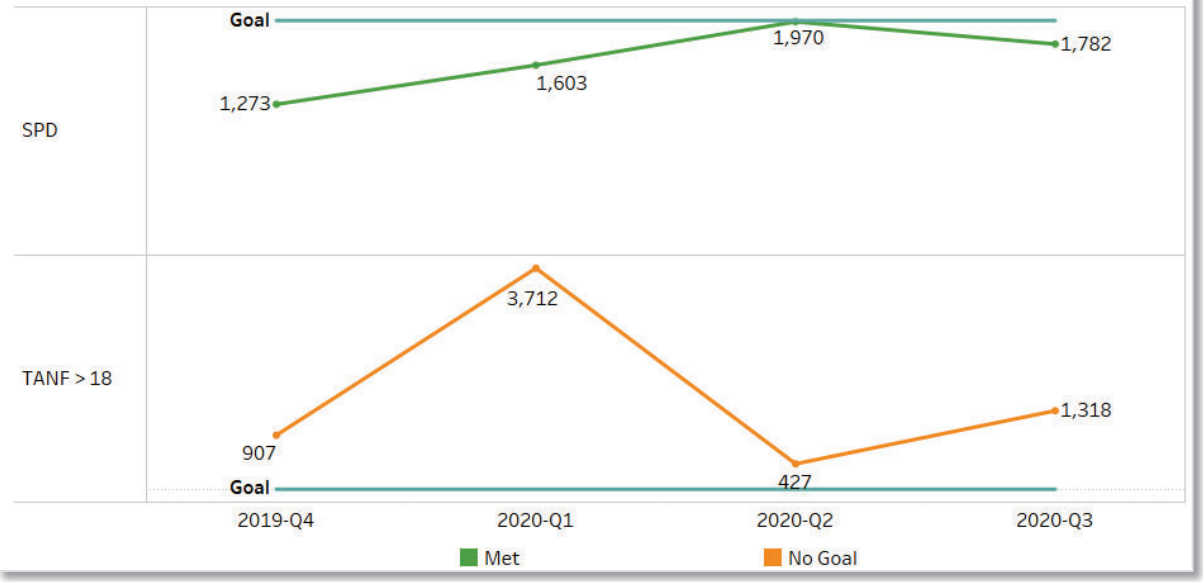
Legend: Goal Met, No Goal

Bed Days PTPMY

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,273	1,980	▼	1,603	1,980	▼	1,970	1,980	▼	1,782	1,980	▼
TANF > 18	907	0		3,712	0		427	0		1,318	0	

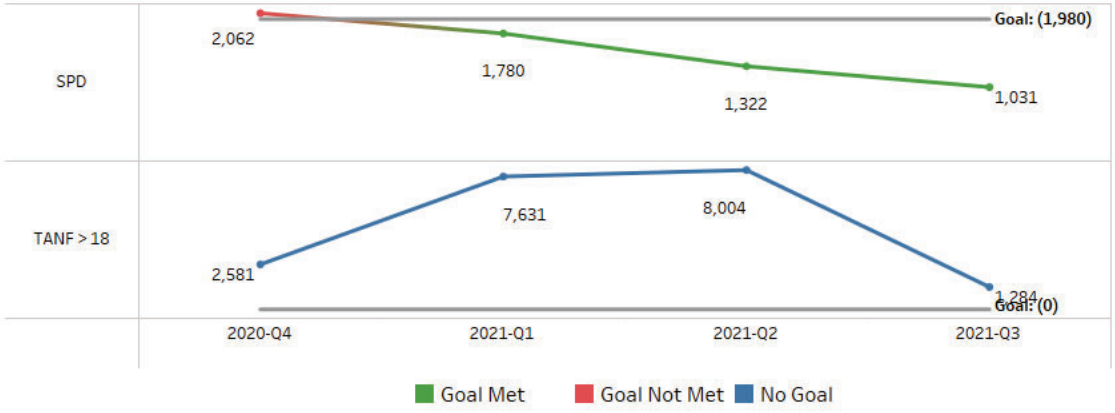


Bed Days PTPMY

Line of Business: OneCare Connect Risk Group: CCN OCC

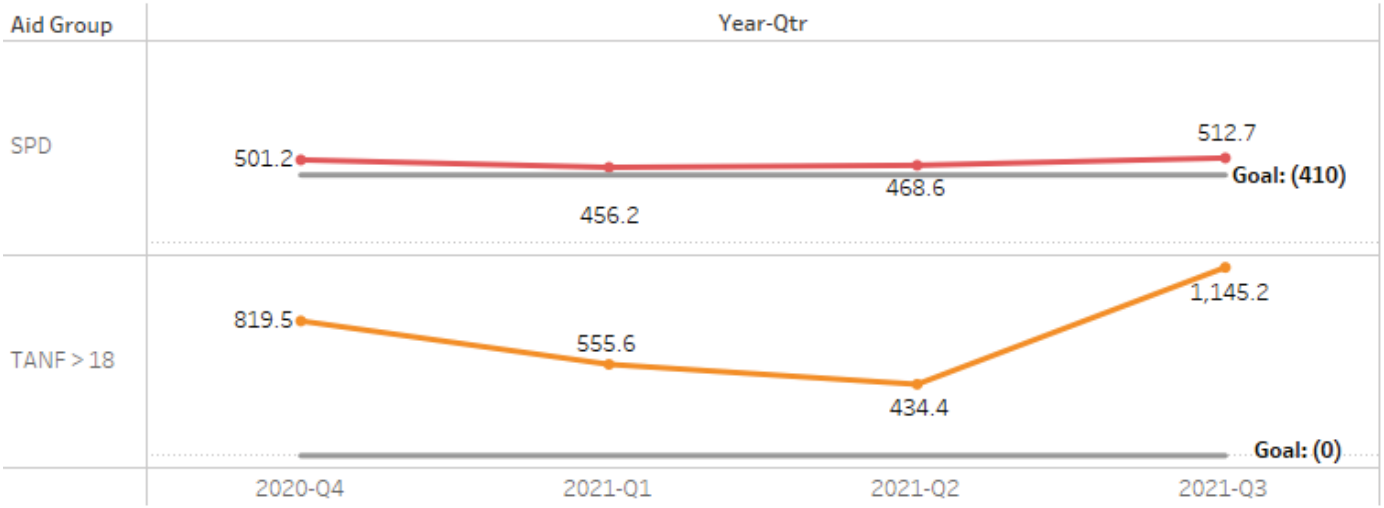
From: October 2020 To: September 2021

	2020-Q4			2021-Q1			2021-Q2			2021-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	2,062	1,980	▲	1,780	1,980	▼	1,322	1,980	▼	1,031	1,980	▼
TANF > 18	2,581	0		7,631	0		8,004	0		1,284	0	



Back To Item Back to Agenda

ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	410	501.2 ▲	456.2 ▲	468.6 ▲	512.7 ▲
TANF > 18	0	819.5	555.6	434.4	1,145.2

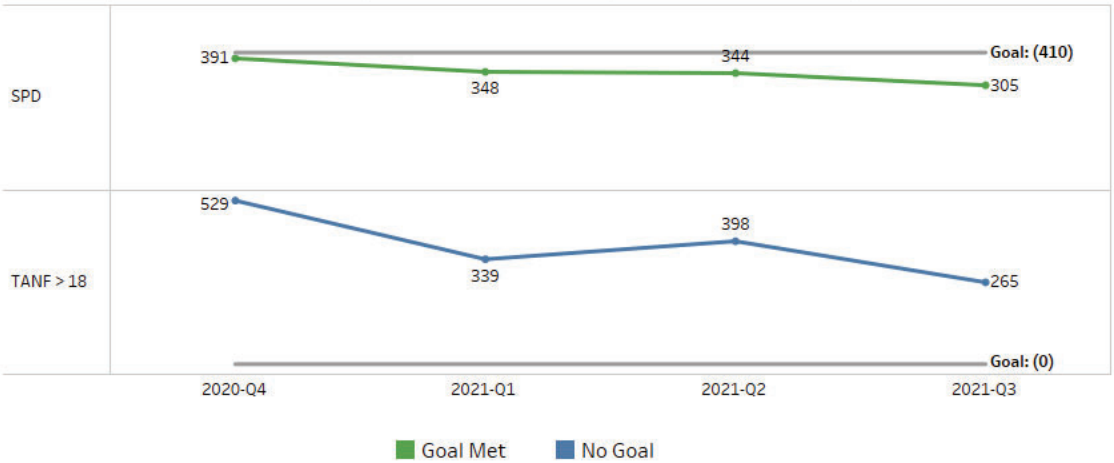
Legend: No Goal, Not Met

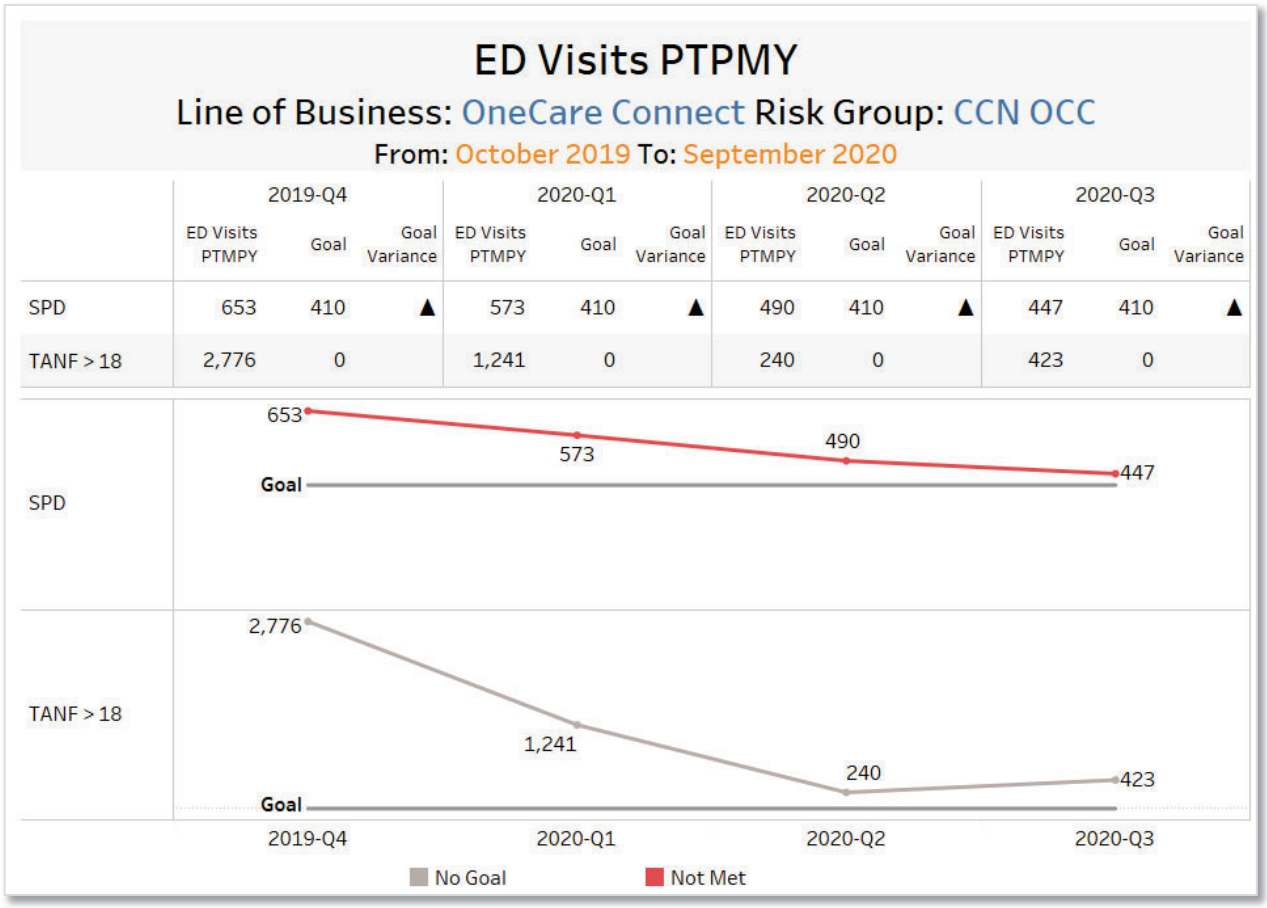
ED Visits PTMPY

Line of Business: OneCare Connect Risk Group: CCN OCC

From: October 2020 To: September 2021

	2020-Q4 ED Visits PTMPY	2020-Q4 Avg. Goal	2020-Q4 Goal Variance	2021-Q1 ED Visits PTMPY	2021-Q1 Avg. Goal	2021-Q1 Goal Variance	2021-Q2 ED Visits PTMPY	2021-Q2 Avg. Goal	2021-Q2 Goal Variance	2021-Q3 ED Visits PTMPY	2021-Q3 Avg. Goal	2021-Q3 Goal Variance
SPD	391	410	▼	348	410	▼	344	410	▼	305	410	▼
TANF > 18	529	0		339	0		398	0		265	0	





OneCare

- **Average Length of Stay:** The SPD population ~~slightly increases~~trended downward from fourth quarter 2020 through first quarter 2021with an uptick during second quarter that slightly decreased third quarter 2021. ~~between Q4 2019 and Q1 2020~~ 2021 ~~and between Q2 2020~~ 2021 ~~and Q3 2020~~2021.~~during the time period with an uptick in Q2 2021.~~
- **Bed Days/PTPMY:** The SPD population consistently met the goal, trending downward for all four quarters, with the exception of Q2 2021.
- **Readmissions:** The SPD population ~~was volatile increased increasing slightly in Q1 2020~~ 2021 ~~and Q3 2020~~2021.demonstrated an uptick in readmissions during first quarter and a significant uptick in second quarter 2021, then dropping significantly during third quarter.
- **ED Visits/PTPMY:** The SPD population consistently met the goal for all four quarters.

Utilization Outcomes

Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

		2019-Q4	2020-Q1	2020-Q2	2020-Q3
SPD	ALOS	4.7	6.1	5.5	6.2
	Bed Days PTMPY	820	860	549	734
	Pcnt Re-Admits	8%	13%	6%	11%
	ED Visits PTMPY	453	401	248	269

Utilization Outcomes

Line of Business: One Care Risk Group: OneCare

From: October 2020 To: September 2021

		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.03	4.96	5.48	5.31
	Bed Days PTMPY	1029.44	707.53	863.86	775.98
	Pcnt Re-Admits	7.90%	11.90%	31.05%	3.45%
	ED Visits PTMPY	348.19	249.42	259.16	251.94

Utilization Outcomes

Line of Business: OneCare Risk Group: OneCare

From: October 2020 To: September 2021

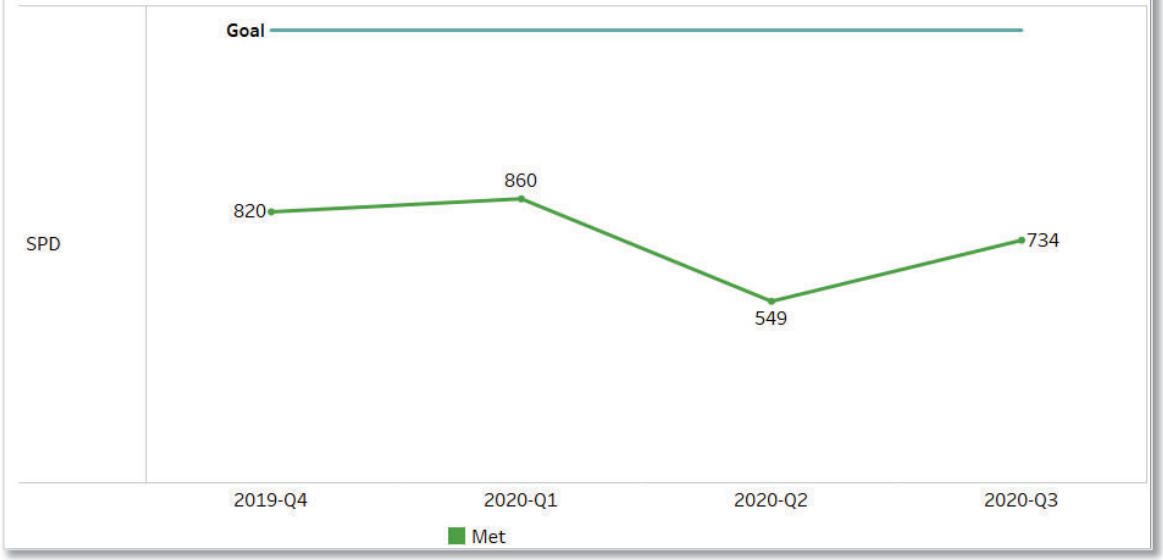
		2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	ALOS	7.5	6.7	7.8	5.0
	Bed Days PTMPY	1,277	1,257	1,419	548
	Pcnt Re-Admits	15%	28%	18%	5%
	ED Visits PTMPY	277	250	313	201

Bed Days PTPMY

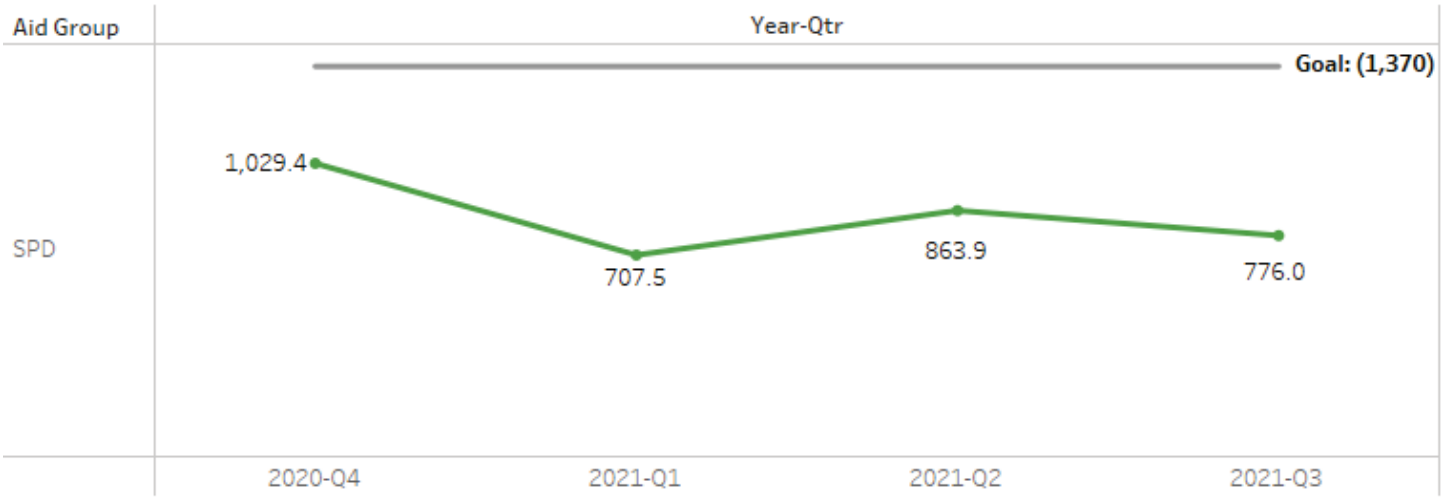
Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	820	1,370	▼	860	1,370	▼	549	1,370	▼	734	1,370	▼



IP Goal Analysis



Aid Group	Goal	Measure / Year-Qtr Bed Days PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	1,370	1,029.4 ▼	707.5 ▼	863.9 ▼	776.0 ▼

Legend

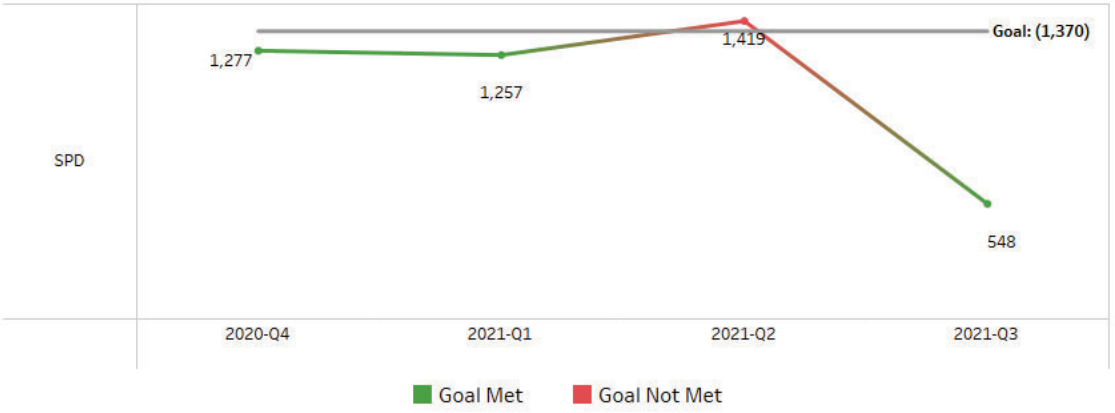
Goal Met

Bed Days PTPMY

Line of Business: OneCare Risk Group: OneCare

From: October 2020 To: September 2021

	2020-Q4			2021-Q1			2021-Q2			2021-Q3		
	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance	Bed Days PTMPY	Avg. Goal	Goal Variance
SPD	1,277	1,370	▼	1,257	1,370	▼	1,419	1,370	▲	548	1,370	▼

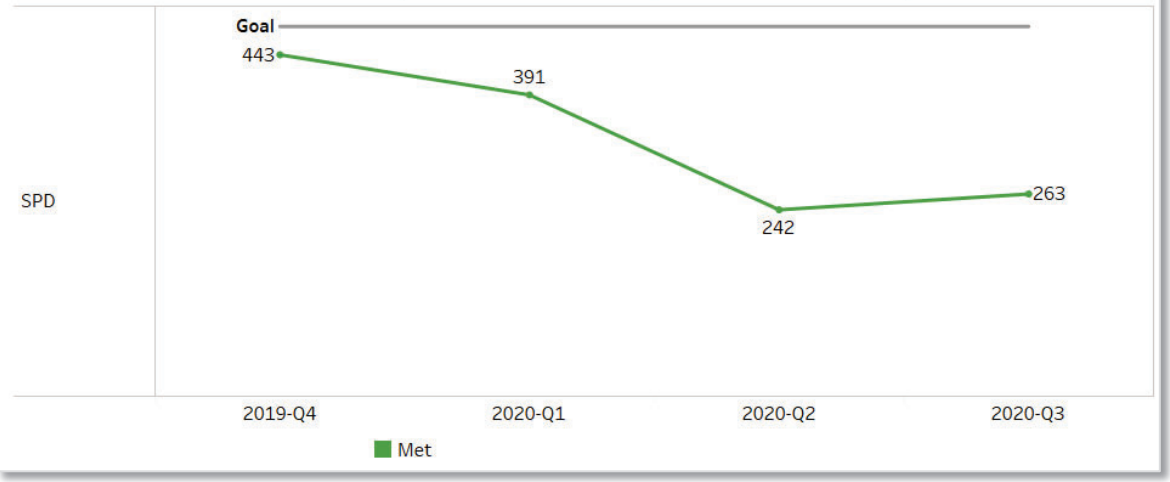


ED Visits PTPMY

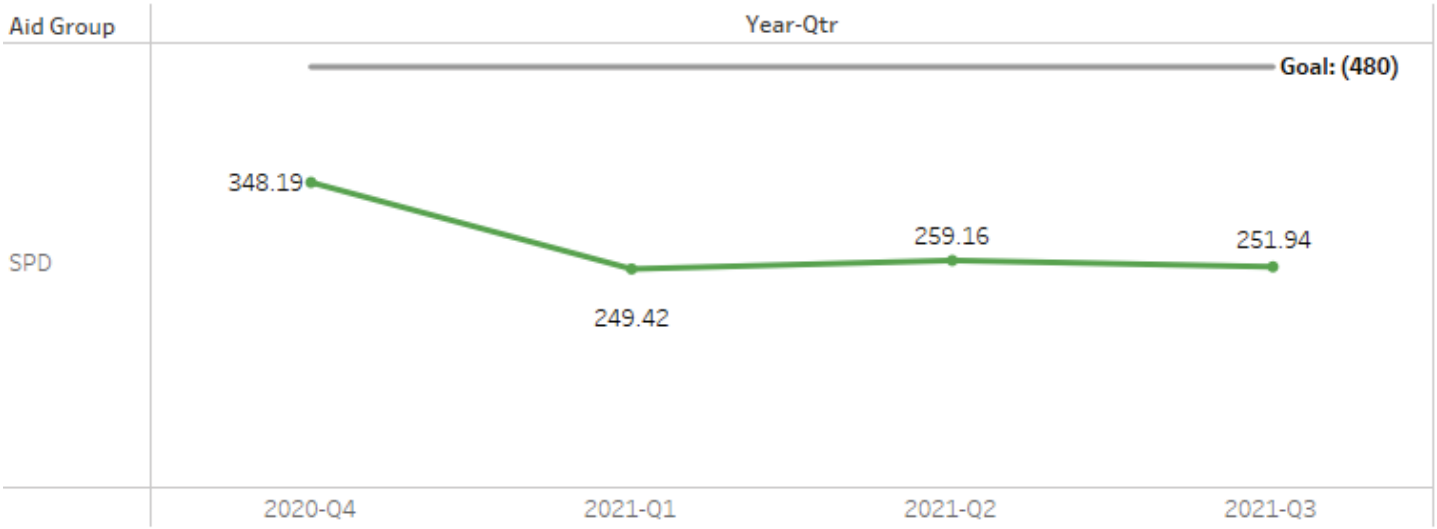
Line of Business: OneCare Risk Group: OneCare

From: October 2019 To: September 2020

	2019-Q4			2020-Q1			2020-Q2			2020-Q3		
	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance	ED Visits PTMPY	Goal	Goal Variance
SPD	443	480	▼	391	480	▼	242	480	▼	263	480	▼



ED Goal Analysis



Aid Group	Goal	Measure / Year-Qtr ED Visits PTMPY 2020-Q4	2021-Q1	2021-Q2	2021-Q3
SPD	480	348.19 ▼	249.42 ▼	259.16 ▼	251.94 ▼

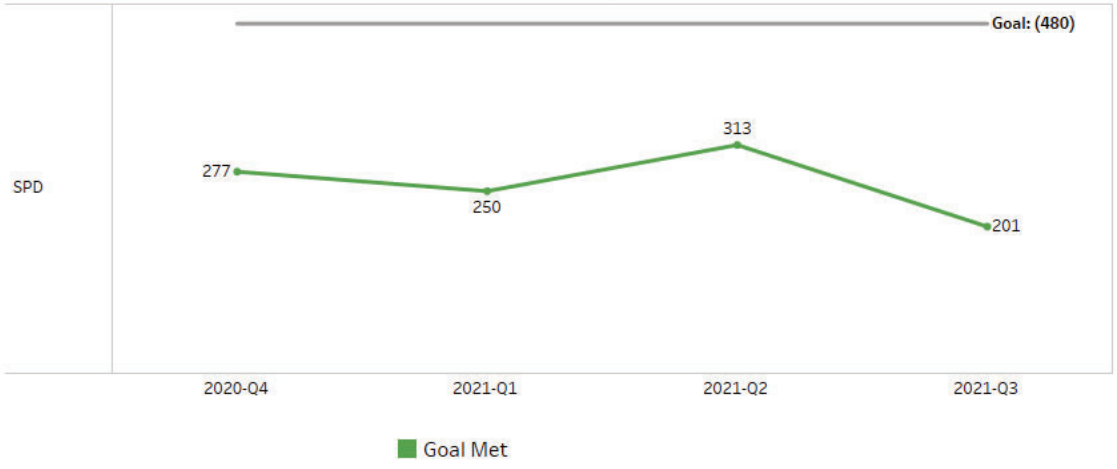
Legend
Goal Met

ED Visits PTMPY

Line of Business: OneCare Risk Group: OneCare

From: October 2020 To: September 2021

	2020-Q4			2021-Q1			2021-Q2			2021-Q3		
	ED Visits PTMPY	Avg. Goal	Goal Variance	ED Visits PTMPY	Avg. Goal	Goal Variance	ED Visits PTMPY	Avg. Goal	Goal Variance	ED Visits PTMPY	Avg. Goal	Goal Variance
SPD	277	480	▼	250	480	▼	313	480	▼	201	480	▼



As identified in section II A Utilization Management above, a significant backlog impacted the

turnaround time for all LOBs during third quarter 2021. Efforts were introduced during fourth quarter 2021 that led to a resolution of the backlog in early 2022.

Turnaround Time Compliance (TAT) Q4 2020 - Q3 2021					
Years	Quarters	LOB	Prospective Routine	Prospective Urgent	Retro / Post Service
2020	Qtr4	Medi-Cal	99.83%	99.44%	99.96%
		OneCare	100.00%	-	-
		OneCare Connect	99.82%	94.12%	100.00%
2021	Qtr1	Medi-Cal	99.87%	99.65%	99.96%
		OneCare	100.00%	-	-
		OneCare Connect	99.85%	100.00%	100.00%
	Qtr2	Medi-Cal	99.69%	99.09%	99.77%
		OneCare	100.00%	-	100.00%
		OneCare Connect	100.00%	98.99%	100.00%
	Qtr3	Medi-Cal	64.99%	92.28%	99.59%
		OneCare	50.00%	100.00%	100.00%
		OneCare Connect	93.69%	97.85%	93.83%
~~Overall, TAT for Reporting Period~~			~~91.45%~~	~~97.30%~~	~~99.77%~~

An increase in Medi-Cal referrals can be seen quarter-over-quarter below with a significant increase during second quarter and a decrease during third quarter consistent with fourth quarter 2020 and first quarter 2021. These volumes demonstrate an increase over prior years.

Referrals Processed Q4 2020 - Q3 2021					
Years	Quarters	LOB	Prospective Routine	Prospective Urgent	Retro / Post Service
2020	Qtr4	Medi-Cal	35,130	3,731	2,275
		OneCare	11	-	-
		OneCare Connect	1,648	204	110
2021	Qtr1	Medi-Cal	36,352	4,247	2,289
		OneCare	11	-	-
		OneCare Connect	1,347	198	72
	Qtr2	Medi-Cal	40,313	4,526	2,577
		OneCare	14	-	1
		OneCare Connect	1,552	199	66
	Qtr3	Medi-Cal	36,857	5,270	2,199
		OneCare	12	1	1
		OneCare Connect	1,679	233	81
Grand Total			154,926	18,609	9,671

Referrals Received Q4 2020 - Q3 2021

Faxes	119,300
COLAS	156,224
COLAS Auto Approved	52,262
Total	275,524

Over and Underutilization

In ~~2020~~2021 we continued to enhance the process for monitoring of over and underutilization ~~was enhanced~~ as organization wide initiative to ensure appropriate monitoring of activities with CalOptima related to over and underutilization and the development of a cross departmental dashboard, maintained by UM. For 2021 we added performance for all CalOptima Medi-Cal members in order to include our health network data and look at the membership as a whole. Metrics were identified throughout the organization as good indicators of over and underutilization, as well as drill down into the metrics to ensure proper identification of over and underutilization. Metrics from the following area are included and will be reviewed on an annual basis to ensure they are indicative of over and underutilization monitoring. The metrics include inpatient and prior authorization UM measure, appeal volumes and overturn rate, member grievances, adult and children's access to PCP services, measures indicative of appropriate utilization for pharmaceuticals, outlier reporting from the fraud, waste and abuse department within CalOptima, referral pattern analyses, member utilization, UM related member complaints, potential quality issues (PQI) monitoring, and measures related to behavioral health care.

Over and underutilization was monitored, tracked, managed, and reported by UM during ~~2020~~2021 and reported to UMC, QIC and the Quality Assurance Committee (QAC). Through quarter 3 of ~~2020~~2021, we identified one area of overutilization related pre-natal ultrasounds being ordered by one physician multiple times, when the recommendation is one ultrasound within 180 days and any others within that period will require prior authorization. Provider education has occurred via a memo and by provider relation outreach.

III. Operational Performance

~~B.~~A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests — Medical

~~2020~~2021 — Summary of referral volume (Q4 ~~2019~~ 2020 ~~2019~~ to Q3 ~~2020~~2021)

Referrals Processed		Referrals Received		Turnaround Time Compliance (TAT)	
Routine	~~138,240~~161,717	Faxed	~~80,324~~119,300	Routine TAT	~~99.22~~86.97 %
Urgent	~~16,918~~19,257	COLAS	~~100,177~~156,224	Urgent TAT	~~99.15~~96.90 %
Retro	~~9,356~~8,954	Auto Auth	~~25,279~~52,262	Retro TAT	~~99.83~~99.69 %
Total	~~155,158~~189,928*	**Total**	~~180,501~~275,524		

~~Referrals Processed~~		~~Referrals Received~~		~~Turnaround Time Compliance (TAT)~~	
~~Routine~~	~~138,240~~	~~Faxed~~	~~80,324~~	~~Routine TAT~~	~~99.22%~~

~~2020~~2021 CalOptima Utilization Management Program

~~Urgent~~	~~**16,918**~~	~~COLAS~~	~~**100,177**~~	~~Urgent TAT~~	~~**99.15%**~~
~~Retro~~	~~**9,356**~~	~~Auto Auth~~	~~**25,279**~~	~~Retro TAT~~	~~**99.83%**~~
~~**Total**~~	~~**155,158***~~	~~**Total**~~	~~**180,501**~~		

- Total volume of referrals shows a year-over-year increase 8,607 (5.9%) based on data from Q1–3 2019 compared to Q4 2019 through Q3 ~~2020~~2021.
- Volume of faxed referrals decreased from Q1–3 2019 by 9,800 or 10.9%
- Volume of portal (COLA) referrals decreased from 2019 report by 365 or .36%
- We did work diligently to improve the non-compliant TAT by focusing efforts on active inventory, or inventory that would not age out of compliance if processed timely. As well as analyze staffing patterns and worked with human resources to backfill vacant full-time positions.

~~It is also worth noting that we have indicated the volume of referrals that were automatically authorized when submitted via our portal, as in April we implemented an auto authorization process for initial consults for 9 specialties, chosen based on analysis of data and meeting an approval rate of 99% or greater.~~

* The difference between referrals received and processed may be attributed to duplicate submissions and/or requests that do not require authorization.

Online Referral Rate Submission

Online referral submission increased over the 3 quarters by 11% in ~~2020~~2021. In 2019, Q1–Q3, there were 91,334 online referrals and during the same period of ~~2020~~2021, there were 100,177.

- Referral TAT was compliant for all referral types in the first 3 quarters of ~~2020~~2021.

~~C.~~B. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

Annual summary of turnaround time compliance through Q3 ~~2020~~2021:

LOB	TAT Compliance
Medi-Cal	99.3~~8.1~~%
OC	~~100~~99.7%
OCC	99.5~~4~~%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans. Pharmacy metric targets were achieved for ~~2020~~2021.

~~D.~~C. Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric

~~2020~~2021 CalOptima Utilization Management Program

targets were achieved for Q4 ~~2020~~2021~~2020~~–Q3 ~~2020~~2021:

- CBAS CEDT: ~~100%~~99.90%
- CBAS Routine: ~~100%~~99.80%
- CBAS Expedited: None received
  - Members participating in CBAS Q4 ~~2019~~ 2020 & Q1–Q3 ~~2020~~2021: Potentially program-eligible members.

Year	Qtr.	LOB	Members Participating in CBAS Q4 2019-Q3 ~~2020~~2021 / Potentially Program-Eligible Members	% Participating	Change from Previous Qtr.
~~2019~~20~~2~~	Q4	Medi-Cal	~~2,590 / 116,463~~2,405/121,676	~~2.22%~~1.98%	~~↑~~No Change
		OCC	~~195 / 14,160~~158/15,055	~~1.38%~~1.05%	~~↑~~↓
~~2020~~2021	Q1	Medi-Cal	~~2,565 / 114,555~~2,455/123,416	~~2.24%~~1.99%	↑
		OCC	~~194 / 14,191~~160/14,764	~~1.37%~~1.08%	↑
	Q2	Medi-Cal	~~2,245 / 105,321~~2,493/124,060	~~2.13%~~2.01%	~~↓~~↑
		OCC	~~170 / 14,408~~145/14,806	~~1.18%~~0.98%	↓
	Q3	Medi-Cal	~~2,384 / 120,253~~2,535/106,491	~~1.98%~~2.38%	~~↓~~↑
		OCC	~~164 / 14,711~~152/14,852	~~1.11%~~1.02%	~~↓~~↑

- 80% of authorized CBAS participation days will be utilized/delivered ~~(Q4 2019~~Q4 2020) to Q3 ~~2020~~2021.

Year	Qtr.	CBAS Participation Days Used / Days Authorized	% Used	Change from Previous Qtr.
~~2019~~ ~~2~~	Q4	~~98,616 / 133,320~~101,674/121,905	~~73.97%~~ 83.40%	↓
~~2020~~2021	Q1	~~89,668 / 129,236~~105,716/121,927	~~69.38%~~ 86.70%	~~↓~~↑
	Q2	~~105,758 / 129,144~~110,287/125,852	~~81.89%~~ 87.63%	↑
	Q3	~~107,255 / 122,417~~133,811/158,466	~~87.61%~~84.44%	~~↑~~[OC1][OC2]↓

- LTC Routine: ~~98.99%~~97.16%
- LTC Urgent: None received
- MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

Year	Qtr.	Admissions/ Discharges	Change from Previous Qtr.
~~2019~~ ~~2020~~	Q4	~~34~~ 31 / 34	~~No Change~~ Admissions ↑
~~2020~~2021	Q1	~~31~~ 33 / ~~28~~21	Admissions ↑
	Q2	~~24~~ 29 / ~~14~~24	Admissions ↓
	Q3	~~19~~ 25 / ~~20~~13	Admissions ↓

- MSSP Goal met. Continue with this goal.

~~E.~~D. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for ~~2020~~2021. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	~~90%~~96.13%
UM Clinical Staff: Concurrent Review	~~90~~98.3%
Physicians	~~97~~98.70%
Pharmacy	100%
LTSS: LTC	~~100%~~Not completed in 2021
LTSS: CBAS	Not completed in 2021~~100%~~
LTSS: MSSP	~~Did not test in~~ [OC3]~~2020~~2021~~99%~~

~~F.~~E. Denial (Letter) Process

Performance has continued to improve throughout ~~2020~~2021. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains

some variability across the HNs. A workgroup begun in ~~2020~~2021 consisting of participants from CalOptima UM, BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further improvement in this area. NCQA ~~2020~~2021 Survey demonstrated full compliance with the denial process across CCN and the HNs selected for review.

IV. Utilization Performance / Outcomes

A. Facility Utilization — Facility Acute and Emergency Care

Analysis of inpatient and ED data in ~~2020~~2021 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.

Review of ~~2020~~2021 ED Data will be conducted, and additional interventions may be applied as needed. LTC Nursing facility members transitioned to the Community:

Year	Qtr.	LOB	LTC Nursing Facility Members Transition to the Community	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	182 / 5,133	3.55%	↑
		OCC	6 / 205	2.93%	↑
~~2020~~2021	Q1	Medi-Cal	163 / 5,181	3.15%	↓
		OCC	6 / 201	2.99%	↑
	Q2	Medi-Cal	148 / 5,192	2.85%	↓
		OCC	7 / 185	3.78%	↑
	Q3	Medi-Cal	158 / 4,738	3.33%	↑
		OCC	4 / 161	2.48%	↓

CBAS: Track CBAS participants who transition to LTC.

Yr.	Qtr.	LOB	CBAS participants who transition to LTC	% Transitioned	Change from Previous Qtr.
2019	Q4	Medi-Cal	8 / 2,590	0.31%	↑
		OCC	1 / 195	0.51%	↓
~~2020~~2021	Q1	Medi-Cal	10 / 2,565	0.39%	↑
		OCC	1 / 194	0.52%	↑
	Q2	Medi-Cal	4 / 2,345	0.17%	↓
		OCC	0 / 170	0.00%	↓

	Q3	Medi-Cal	7 / 2,384	0.29%	↑
		OCC	0 / 164	0.00%	←

LTC: Members residing in LTC: Potentially nursing home eligible members.

Year	Qtr.	LOB	Members Residing in LTC/ Potentially Nursing Home Eligible Members	% Residing in LTC	Change from Previous Qtr.
2019	Q4	Medi-Cal	5,133 / 116,443	4.41%	↓
		OCC	205 / 14,168	1.45%	↓
~~2020~~2021	Q1	Medi-Cal	5,181 / 114,555	4.52%	↑
		OCC	201 / 14,191	1.42%	↓
	Q2	Medi-Cal	5,192 / 105,321	4.93%	↑
		OCC	105 / 14,408	0.73%	↓
	Q3	Medi-Cal	4,738 / 120,253	3.94%	↓
		OCC	161 / 14,711	1.09%	↑

B. Pharmacy Utilization

- Retail Pharmacy: $PMPM costs from 4Q20~~19~~ to 3Q2~~1~~0 are below goal for ~~OneCare and~~ Medi-Cal, and above goal for OneCare and OneCare Connect. ~~Medi-Cal pharmacy costs increased 7% after the start of the Whole Child Model (WCM) on July 1, 2019~~. OneCare and OneCare Connect drug cost increases are primarily driven by increased utilization of diabetes medications as well as drug price increases for a large number of branded medications.

LOB	Goal $PMPM	Actual $PMPM (Q4 2019–Q3 2021)
Medi-Cal	$~~71.57~~75.14	$~~71.11~~72.30
OC	$~~370.76~~389.29	$~~370.10~~410.56
OCC	$~~420.44~~441.46	$~~433.98~~451.19

- ~~Opioid analgesic utilization (average morphine milligram equivalent) has decreased 11.2% from 4Q19 to 3Q20.~~

C. Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:

- Providing information to members and providers about the UM Program
  - Members are informed about authorization requirements through the Member Handbook and member newsletters.
  - New member orientation is available for all CalOptima members to better understand their benefits.
  - Access to a list of services requiring pre-authorization is also available on CalOptima's website.
  - CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed.
  - Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members.
  - A Provider Toolkit is available on the CalOptima website for provider reference.
  - CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers.
- Ensuring timeliness and notification of UM decisions
  - Monitored and reported quarterly to UMC: In ~~2020~~2021, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making.
  - Monitored monthly by the A&O Committee
  - Variation among the delegated HNs
  - Additional training provided as needed.
  - Overall improvement in audit scores for clinical decision making in ~~2020~~2021.

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In ~~2020~~2021, complaints about the UM Program demonstrated some trends in the following categories:

- Member concerns:
  - Access to providers, specifically providers no longer contracted with CalOptima.
  - Provider not seeing new patients.
  - Provider was unable to see the member due to the type of care the member required or the members age was not in the scope of their specialty practice.
  - Limitation of members ability to see certain providers, as there are some

providers who only see members already affiliated with their organization.

- Provider concerns:
  - Most complaints from providers were related to changes in our portal to safeguard PHI and inability for them to self-serve to obtain information about their referral.

CalOptima is continually looking at improving access to providers, including alternative types of visits, such as telehealth. All member issues were resolved by either redirecting the members care to another specialist that is able to meet the member's needs. We are looking at ways to improve provider data in our systems, including finding a new product to use for provider data management that interfaces with multiple systems. Provider relations has also worked very diligently to ensure the provider data is accurate, by confirming information accuracy with providers.

Access to authorization data has been mitigated by adding safeguards within the portal to verify the provider has a relationship with the member and displaying the members phone number only on authorization notices to limit PHI exposure and ensure the provider is able to reach out to the member to deliver necessary care.

V. SUMMARY

In ~~2020~~2021, UM encountered a backlog of treatment authorization requests identified in Q3'2021 and initiated early interventions that ultimately were unsuccessful in addressing the backlog of inventory and maintaining turn-around-time compliance. CalOptima implemented internal structural changes in attempt to improve ~~made progress improving~~ the effectiveness of the UM program. CalOptima enhanced monitoring protocols internally to oversee delegated health networks ~~and decreasing administrative barriers through the implementation of auto authorizations for select specialties.~~ Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on Compliance, maintenance of current policies and procedures, report development.

The UMC and the UM Medical Director and Behavioral Health Medical Director continue to guide and support CalOptima UM programs, both medical and behavioral. The UMC met virtually six times in ~~2020~~2021 due to the public health emergency~~, with two of the meeting being virtual~~. Pharmacy and Therapeutics Committee (P&T) and the BMSC reported quarterly to the UMC in ~~2020~~2021. Quarterly UM operational performance and health care utilization data and over and underutilization analysis and trends are presented, reviewed, and discussed at the UMC and guide future efforts of the CalOptima UM Program.

2022
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

2021 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Himmet Dajee, M.D. **Date**
Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Chair:

_____ _____

Supervisor Andrew Do **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve quality care and service across the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.
- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain

historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
In 2019, CalOptima's Board and executive team worked together to develop the 2020–2022 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services
CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that began in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (HCA).
- Substance use disorder services are administered by HCA.
- Dental services are provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs
To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:
- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)
Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. [CM1][GV2][RJ3]Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

Scope of Services
In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal. The demonstration program will end on December 31, 2022, and members in OCC will transition to OC.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and worldwide urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants.

PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Improve Health Equity and Mitigate Impact: COVID-19 Public Health Emergency (COVID-19 PHE)

COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy. Additionally, UM requirements for COVID-19 PHE screening, vaccination and COVID-19 PHE related care are waived during the PHE. Also, authorizations approved during the PHE have been and will continue to be updated until the end of the COVID-19 PHE.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as detailed in its QI Work Plan.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 Draft CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, where people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM), and stresses DHCS' commitment to health equity, member involvement, and accountability in all program and initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and patient-centered chronic disease management
- Providing whole person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency accountability, and member involvement

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

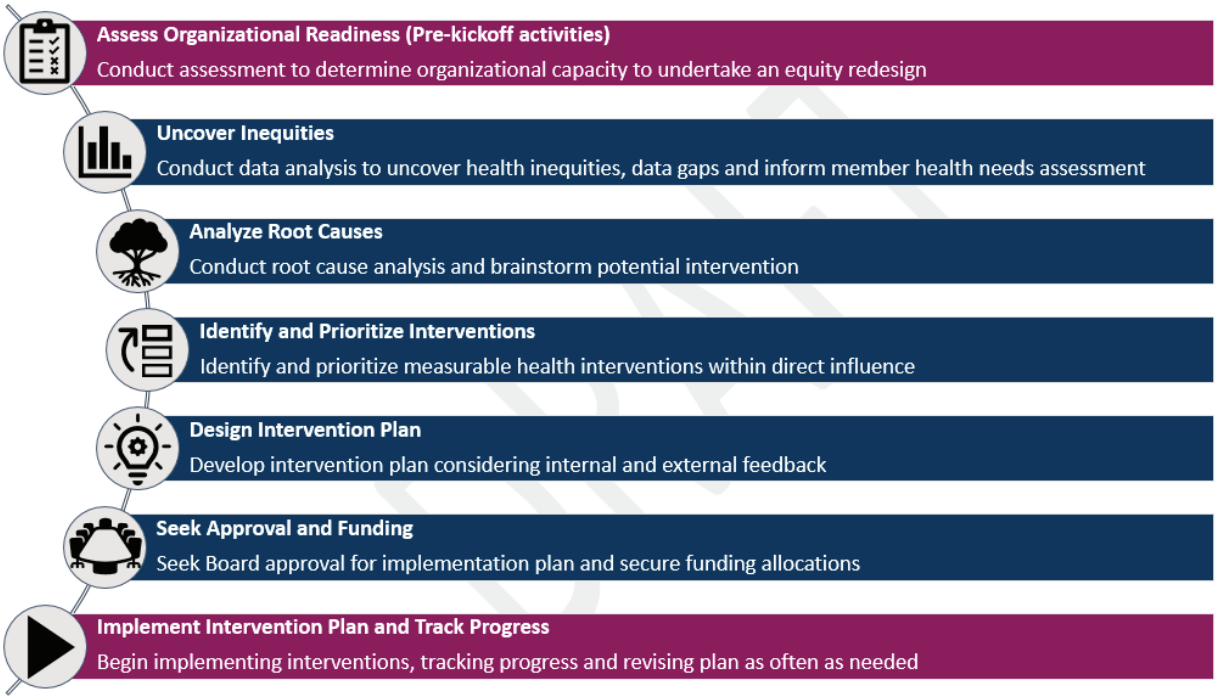
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparity[GV4][GV5]

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." (Centers for Disease Control and Prevention)

Social determinants of health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship, and age that affect health outcomes. (Henry J. Kaiser Family Foundation)

In response to CalOptima' strategic plan, staff began the process to identify and address health equity and social determinants of health (SDOH) for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes, designing comprehensive intervention plan, to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.



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Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical

conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with HCA.

California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reforms across Medi-Cal.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing social determinants of health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Enhanced Care Management and Community Supports

On January 1, 2022, CalOptima implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays.

CalOptima's implementation of ECM and Community Supports builds upon the Health Homes Program (HHP) and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima's HHP Community-Based Care Management Entities have transitioned to become ECM providers. This means that CalOptima and its delegated health networks (HNs) are providing ECM services as ECM providers to eligible populations. ECM providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

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
7. Coordination of and Referral to Community and Social Support Services

On January 1, 2022, ECM went live for the following populations of focus:

- Members experiencing homelessness (adults and children)
- High utilizer adults
- Adults with Serious Mental Illness (SMI)/substance use disorder (SUD)

Additionally, members participating in WPC and/or HHP will automatically transition into ECM.

HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand its network of Community Supports providers that have the expertise and capacity to provide the specific types of services needed. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:

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 (Home Modifications)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

Beginning January 1, 2022, CalOptima will offer the following four, distinct Community Supports services:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Recuperative Care

CalOptima will continue to assess the needs the members and collaborate with community stakeholders to add new Community Supports.

2021–22 CalOptima Community Network (CCN) Pilot Program — Diabetes Mellitus (DM) Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics

To address high rates of poorly controlled diabetics identified in CCN, the following pilot program was proposed and approved by the CalOptima Board.

1. Pharmacist Involvement and Intervention
   CalOptima Pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dietitians/case managers.
2. Health Coach/Registered Dietitian Management Intervention
   CalOptima Health Coaches will provide CCN-focused interventions, such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dietitians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.

3. Non-Monetary Member Incentives
   CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.
4. Provider Incentives
   In order to have successful provider buy-in, CalOptima proposes offering provider incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect OneCare, OneCare Connect or PACE.

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM 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 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as 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. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

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. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs[RJ6]. Quality Initiatives for 2021 are tracked in the QI Work Plan and reported to the QIC.

In 2021, the PHM Strategy was focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as a public health issue in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined.
- Have specific objectives and timelines.
- Specify responsible departments and individuals.
- Be evaluated for effectiveness.
- Be tracked by QIC.

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, will be developed and implemented.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs providing health care to CalOptima members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN).

CalOptima members can choose CCN or one of 12 HNs, representing more than 10,000 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

- CalOptima Direct-Administrative (COD-A)
  CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, newly eligible members transitioning to a HN from CCN, and members residing outside of Orange County.

- CalOptima Community Network (CCN)

  The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks
CalOptima has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima members have access to 1,500 primary care providers (PCPs), more than 8,900 specialists, 41 hospitals, 34 clinics and 99 long-term care facilities.[CM7][RJ8]

CalOptima contracts with the following HNs:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Optum Care Network - Arta	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Medical Group	PHC	SRG	SRG

HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Optum Care Network - Monarch	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Optum Care Network - Talbert	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex case management
- Claims
- Contracting
- Credentialing of practitioners
- Customer services

MEMBERSHIP DEMOGRAPHICS[RJ9]

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2022

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

Membership Data from November 30, 2021, Financial Information

Total CalOptima Membership
867,182

Program	Members
Medi-Cal*	849,616
OneCare Connect	14,877
OneCare (HMO SNP)	2,274
Program of All-Inclusive Care for the Elderly (PACE)	415

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
27%	6 to 18
33%	19 to 44
18%	45 to 64
12%	65+

Languages Spoken (All Programs)

59%	English
26%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

41%	Temporary Assistance for Needy Families
35%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
5%	People with Disabilities
<1%	Long-Term Care
<1%	Other

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. Additionally, access to appropriate services, providers and care settings. [RJ10]The UM Program incorporates physical and behavioral health, pharmacy services, and post-stabilization care across all care settings. This includes preventive, emergency, primary, specialty,

home- and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care and pharmacy services in accordance with state and federal laws, regulations, contract requirements, NCQA standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on medical necessity and/or benefit coverage.
- Identify and refer high-need members to Case Management programs, including Complex and Enhanced Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify and report potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify and address over- and underutilization of services.
- Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- Promote improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Educate, monitor and evaluate practitioners and other providers, including delegated HNs on delivery of CalOptima's UM Program, policies and procedures on an ongoing basis.
- Provide continuous identification of UM staff needs, and appropriate training delivered to address those needs, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to ensure that the member receives appropriate, cost-efficient, quality-based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/benchmarks at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is overseen by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains accountabilities for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit & Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs' UM activities by the Audit & Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA, and CalOptima standards and program requirements.
- Annual approval of the delegate's UM Program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation review, or de-delegation.

Long-Term Support Services

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
    - Nursing Facility Level B (NF-B)
    - Nursing Facility Level A (NF-A)
    - Subacute: Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.
- In April 2020, all LTC member facility clinical reviews and medical necessity nursing facility visits were suspended due to the COVID-19 PHE. All clinical review is now performed electronically and telephonically.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and peopel with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT). In April 2020, all CBAS member and facility clinical reviews and medical necessity visits were suspended due to the COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically.
- MSSP: Home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. Starting in April 2020, all MSSP member and facility clinical reviews and medical necessity visits were suspended due to the COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically.

Behavioral Health Services

Medi-Cal

CalOptima offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Services include but are not limited to individual and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima also covers Alcohol Misuse Screening and Counseling (AMSC) services provided to members 18 and older in the primary care setting.

CalOptima covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavior analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

OC and OCC
CalOptima offers the following mental health services to OC and OCC members:

- Outpatient mental health care including but not limited to individual and group psychotherapy, medication management, psychological testing, intensive outpatient program (IOP), and partial hospitalization program (PHP).
- Inpatient mental health care in either a psychiatric or general hospital.
- Opioid Treatment Program (OTP) services.
- Alcohol Misuse Screening and Counseling (AMSC) services.

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the OC and OCC behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

Authority, Boards Of Directors' Committees, And Responsibilities

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's state and federal contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The Board ensures the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO.

Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) has 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care Representative
- Medi-Cal Beneficiaries
- Medical Safety Net Representative
- Orange County Health Care Agency (standing seat)
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and has 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership has representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA, Behavioral Health
    - SSA
    - OC Community Resources Agency, Office on Aging
    - OC IHSS Public Authority

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. PAC members represent a broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets at least quarterly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) when it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC has 11 voting seats:

- Family representatives: seven seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services.
- Interests of children representatives: four seats
    - Community-based organizations; or
    - Consumer advocates

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM), makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The EDCO is expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED of Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served.

Medical Directors have primary assigned roles but may provide coverage and back up to other specialties as needed. All medical directors are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program.

- The medical director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. The medical director provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the biweekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

- The medical director who oversees the behavioral health program is a participating member of the UMC, QIC and CPRC. The medical director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

- The medical director who oversees specialty programs and services is a key member of the medical management team and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's UM Program for CalOptima Community Network, CalOptima Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups and operational meetings.

Director, Behavioral Health Services is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM Program. The director tracks, analyzes and reports to senior staff on changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and BH care services. The director is responsible for the day-to-day operation of the program overseeing a team of care managers, medical case managers and medical authorization assistants who support all BH UM functions. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. This position provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agencywide population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director, Audit & Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The director ensures that CalOptima and subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director is responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. The position interacts with the Board of Directors, CalOptima executives, departmental management, HN management and legal counsel.

RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Manager, Utilization Management (Prior Authorization [PA]) manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with

physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs and SRGs, and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Monitoring Nurses – UM (Medical Care Manager (LVN)) provide monitoring of referrals and specific UM initiatives to ensure compliance with UM requirements. Monitoring activities include monitoring referrals including inpatient and outpatient, WCM, findings on Correction Action Plans (CAPs) from both internal and external audits, as well as identify opportunity for improvement when identified during the monitoring process.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, research, develops, and updates drug UM strategies and intervention techniques. The
Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T)

Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:
Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high-quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and act as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

Program Manager, LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department, specifically with regard to operational and regulatory reports. The manager 1) leads collaborative efforts as an LTSS liaison, educator and coach with the CBAS centers, LTC Nursing Facilities, MSSP and the IHSS program to meet regulatory compliance procedures; 2) works with the LTSS Manager to lead the implementation and ongoing maintenance of the LTSS program policies and desktop procedures to ensure reporting requirements are met; 3) gathers and validates LTSS data to submit for DHCS reporting requirements and CalOptima QI Program; 4) works with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; 5) supports long-term departmental sustainability efforts; and 6) completes other activities related to the development and implementation of the LTSS program.

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services, Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The supervisor will also oversee and assist Care Managers

with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

Medical Case Managers (BH-RN) are responsible for reviewing and processing authorization requests for inpatient and outpatient behavioral health services. Medical Case Managers adhere to CalOptima's prior authorization approval process, which includes reviewing authorization requests for medical necessity and consulting with managers and CalOptima medical directors as needed. The position is responsible for learning and utilizing CalOptima's medical criteria, UM criteria, and related policies/procedures for authorization and referral requests from BH and ABA providers.

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. The manager uses medical criteria, and policies and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers.

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

Qualifications and Training
CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training
- OC and OCC Training

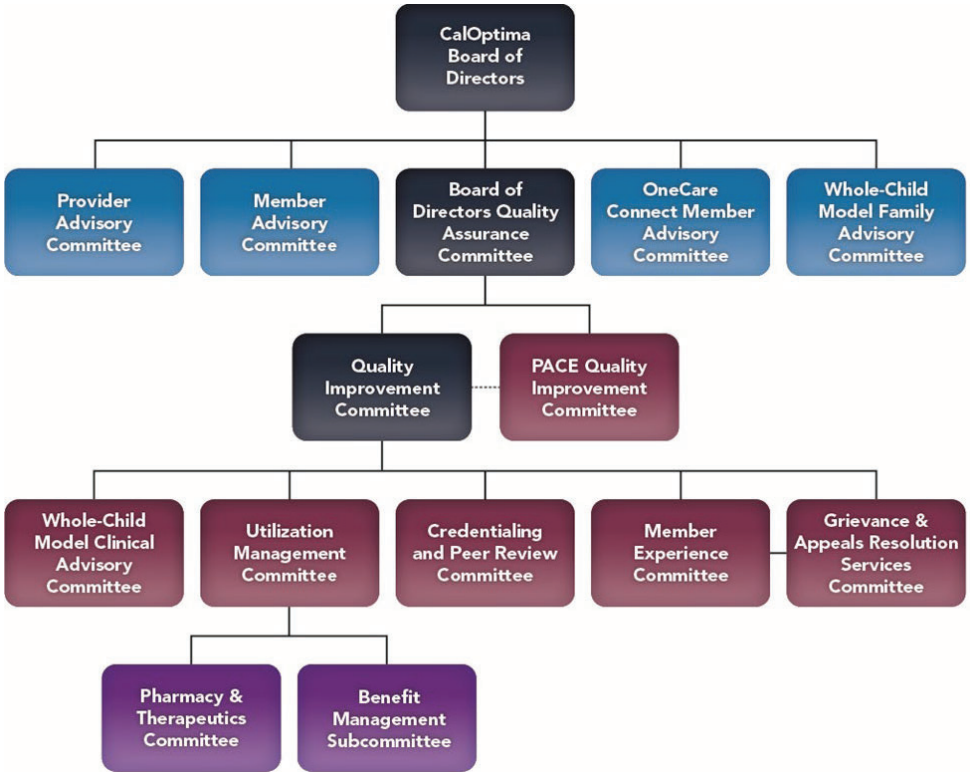
CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each

year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff are required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2022 Committee Organization Structure — Diagram



UMC

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM Program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC, which reports up to QIC and ultimately to QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM Program,

consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HNs.

- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals.
  - UM Workgroup
  - LTSS

- Reports to the QIC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

UMC Membership

Voting Members:

- CMO
- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees Specialty Programs
- Medical Director who oversees Whole-Child Model Program
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director who oversees UM services— Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets quarterly, at minimum, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or underutilization is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.

- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, LTSS Programs, P&T, QI, Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process uses quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the department of compliance and assigned privacy officer. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs and SRGs hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

UM Process

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization inpatient services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit & Oversight department via its delegation oversight team for compliance.

Review and Authorization of Services

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances appropriate clinical criteria and CalOptima polices, applying current evidence-based guidelines, and consideration of available services within the local delivery system on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessarily means all covered services or supplies that:

- For Medi-Cal, covered services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal members under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d® and California Welfare and Institutions Code sections 14132(v).
- For children under 21, Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illness conditions may be approved under Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
- For Medicare, covered services that are reasonable and necessary for 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 section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with

timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services in accordance with CalOptima Policy and Procedure HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process.

- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service authorization request; for OC/OCC all member notifications as listed above and notice of approval.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior Authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Provider Portal allows for non-urgent online authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals

A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of-network practitioners.

Second Opinions

A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "CalOptima policy and procedure, GG.1112: Standing Referral to Specialist Practitioner or Specialty Care Center, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers

If a member or provider requires or requests an out-of-network provider for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network

provider of the same specialty and expertise, lack of network expertise

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the OneCare/Connect (OC/OCC) Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations

Medi-Cal
Effective January 1, 2022, the outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medi-Cal/Medicare
CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

Behavioral Health Determinations

Medi-Cal
CalOptima's BH department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, DHCS All Plan Letters (APL) and CalOptima policy (approved by DHCS).

Medi-Cal/Medicare
CalOptima has previously delegated Magellan Health Inc. to directly manage the BH UM functions for OneCare/OneCare Connect. [RJ11]Effective January 1, 2020, CalOptima's BHI department performed prior authorization review functions for OC/OCC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL) and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed CalOptima Psychologist or Medical Director. CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal timeframes and the member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM Criteria

CalOptima conducts Utilization Review using UM criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:[RJ12]

Medi-Cal

1. Federal and State Law Mandates (i.e., Department of Health Care Services — Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
    a. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

2. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

3. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)

4. Other: US Preventative Services Task Force, Guideline Central
    a. https://www.uspreventiveservicestaskforce.org/
    b. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and CCS Program Information Notices for decisions related to CCS and Whole-Child Model
    a. https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

2. Follow Medi-Cal hierarchy listed above.

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates — CMS, DMHC
    a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
        i. https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

2. Department of Health Care Services
    a. Medi-Cal Provider Manual
    b. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

3. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

4. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
    a. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Delegated HNs must utilize Medi-Cal & Medicare Guidelines, Title 22, and national evidenced based guidelines.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific,

and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Attachment A
TIMEFRAMES FOR MEDI-CAL

Authorization Types

Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse **	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG, updated annually/Medi-Cal an Medicare Manuals/CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Diagnostics	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Hearing Aids	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Home Health	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Imaging	MCG/Medi-Cal and Medicare Manua		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Injectables	MCG/Medi-Cal and Medicare Manua		X	X
Inpatient Hospital Services	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Medical Supplies (DME Related)	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG/Medi-Cal and Medicare Manua	X	X	X

Office Visits (Follow-up)	MCG/Medi-Cal and Medicare Manua	X	X	X
Orthotics	MCG/Medi-Cal and Medicare Manua		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters fo WCM	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Prosthetics	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Radiation Oncology	MCG/Medi-Cal and Medicare Manua		X	X
Therapies (OT/PT/ST)	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	
Transplants	DHCS Guidelines/MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria, and no clinical judgment is required.

** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director/ Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determinati Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services/Title 22, CCR, Section 5133		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services/Title 22, CCR, Section 5133		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services/Title 22, CCR, Sections 510 and 51303		**X**	**X**

Long-Term Care: Intermediate Care Facility/Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services/Title 22, CCR, Sections 513 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11 Criteria for Hospice Care/Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director/Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer/ Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	**X**		**X**
Behavioral Health Treatmen (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-

service to review all required provider trainings, including operational and clinical information such as UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability
At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the Committee.

Provider and Member Communication
Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **711**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned on the next business day and communications received after midnight on Monday–Friday are responded to on the same business day.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g., sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima. In cases requiring immediate response the vendor staff notifies CalOptima on-call nurse. CalOptima will review and process authorizations outside business hours, as necessary, including decisions to deny or modify authorization requests which are made by CalOptima on-call UM physician. A log is forwarded by the vendor to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer
The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided

verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care[RJ13], our UM system.

UM Staff Access to Clinical Expertise
The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, have the authority, accountability, and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records
During prospective and concurrent review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member
CalOptima's UM Program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

Attachment A
TIMEFRAMES FOR MEDI-CAL

UM Decision and Notification Timelines

Medi-Cal (Excludes Pharmacy Requests)[RJ14]

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 with 5 working days[1] of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 1 calendar days following receip of request. "all information" means: Service requested (CPT/HCPC code and description), complet 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

Attachment A

TIMEFRAMES FOR MEDI-CAL

Routine (Non-Urgent) Pre-Service (Deferral), Extension needed:* • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination o tests to be performed Extension is allowed ***only*** if member or provider requests the extension, or the Plan justifies a need for additiona 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 Receive** within the required timeframe, will be considered a denial and therefore constitutes an Adverse Benefit Determinatior on the date the timeframe expires- not to exceed 28 day	**Extension – Practitioner:** Oral or electronic notification within 24 hours of making the decision to delay. **Practitioner/Member:** Written NOA "delay" notification within14 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 gra an extension. 3) The [BJ15][SM16]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

Attachment A
TIMEFRAMES FOR MEDI-CAL

Type of Request	Decision	Notification Timeframes
Expedited Requests (Pre-Service)*: No extension requested or neede Requests where a provider indicate 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 receive 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 an is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood tha receipt of such information would lead to approval of the request.	May extend up to 14 calendar days upon expiration of the 72 hour timeframe. **Additional Requested Information is Received:** A decision must be made with 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 o 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 decisio to grant an extension 3. The anticipated date when a decision will be rendered.

Attachment A
TIMEFRAMES FOR MEDI-CAL

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 unt the enrollee's treating provider has been notified of the plan's decision, and a care plan has bee agreed upon by the treating provider that is appropriate for th 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 timel 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 th 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 afte 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 Titl 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review*: All necessary information received at time of th request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determinatior	**Practitioner:** Written notice withi 30 calendar days from receipt of request. **Member:** Adverse Determinatio Only within 30 days of receipt of request
Post-Service*: Extension needed	**Additional Clinical Informatior 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 da 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 withi 30 calendar days from receipt of th Request. **Member:** Within 30 days of receipt of request

Type of Request	Decision	Notification Timeframes
	Additional Clinical Information Incomplete o Not Received: Decision must be made with t information that is available b the end of the 30th calendar day given to provide the additional information.	
Hospice - Inpatient Care*:	Within 24 hours of making th decision.	**Practitioner:** Oral or electronic notification with 24 hours of making the decision. **Member** Adverse Determination Only**:** Written notice within 2 working days of making the decision.

Medicare

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service: No extension requested or neede	Within 5 working days of receipt "all information" reasonably necessary to render a decision, and in all circumstances no longe than 14 calendar days. "all information" means: Complet 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 tes 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. Ther is reasonable likelihood that recei 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 1 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 2 calendar days from receipt of t 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 calenda 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 the disagree with the decision to grant an extension **Note:** The health plan must respon 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.

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 receive 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 fro receipt of request. **Practitioner/Member:** Written notice within 2 working days of making the decision.

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 disagre with the decision to grant an extension. 3. The anticipated date whe a decision will be rendere **Additional Requested Information is Received:** A decision must be made within 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, an 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.

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 unt the enrollee's treating provider ha been notified of the plan's decisio 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 necessar 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 Informatio 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 Informatio 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 request.

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.

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal Pharmacy Timeframes for Determinations	OC and OCC Pharmacy Timeframes for Determinations (Part D)
Standard (Non-urgent) Pre-Service: Within 24 hours a decision to approve, modify, deny or defer is required. Standard (Non-urgent) Pre-Service, Extension Needed: Within 5 working days of receiving needed information, but no longer than 14 calendar days Expedited (Urgent) Pre-Service/ Concurrent: Within 24 hours a decision to approve, modify, deny or defer is required. Expedited (Urgent) Pre-Service/ Concurrent, Extension Needed: Within 72 hours of the initia request Post-Service/Retrospective: Within 30 days of receipt	Routine: 72 hours Urgent: 24 hours Retrospective: 14 days
Pre-Service and Concurrent Approvals: Provider: Electronic/written: Within 24 hours of making the decision. Pre-Service and Concurrent Denials: Provider: Electronic/written: Within 24 hours of making the decision. Member: Written: Within 2 business days of making the decision. Post Service/ Retrospective Approvals: Practitioner: Written: Within 30 days of receipt of request. Post Service/ Retrospective Denials: Practitioner: Written: Within 30 days of receipt of request. Member: Written: Within 30 days of receipt of request.	**Authorization Request Type:** **For expedited requests:** **Written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.**

Medi-Cal Pharmacy Timeframes for Determinations	OC and OCC Pharmacy Timeframes for Determinations (Part D)
	For standard requests: **Written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar** **days of the oral notification.** **For retrospective requests:** **Written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.**

Emergency Services

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

A non-contracted hospital must submit a Prior Authorization Request for Post-Stabilization Services when a member who has received emergency services for an emergency medical condition is determined to have reached medical stability, but requires additional, medically necessary inpatient covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition. The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) do not apply to contracted providers in CalOptima's Medi-Cal program. CalOptima or a HN shall approve or deny a prior authorization request for post-stabilization services and all information reasonably necessary and requested to render a decision from a non-contracted hospital within 30 minutes after receiving such request and information for Medi-Cal members, and within 60 minutes after receiving such request and information from a non-contracted hospital for OC or OCC members. If CalOptima or the HN does not respond within the prescribed timeframe, medically necessary post-stabilization inpatient services are considered approved.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director of UM, or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director of UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

Contracted facilities are required to notify CalOptima of all inpatient prior-authorized admissions within one (1) business day following the actual admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., pre-service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate a safe, cost-effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort among the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multidisciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner.

Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is written in lay language that is easily understandable at the sixth grade level and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

GRIEVANCE AND APPEAL PROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, OC or OCC members wish to exercise their right to review the UM decision to deny, delay or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in gathering information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay,

termination, or modification of care or service. The UM or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Fair Hearing

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC and OCC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring

services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

Long-Term Services and Supports

LTC

The LTC case management program includes authorizations for the following facilities:

- NF-A, NF-B, subacute care

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: On-site NFs where CalOptima nurses make monthly or bimonthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for on-site only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when a member needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff through monthly on-site visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP

CalOptima has responsibility for the payment of MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help people 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety, and activities of daily living.

TRANSITIONS OF CARE

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from acute care hospitals (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a PHR to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the current Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members

through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician and facilities are assisted in order to assure timely, efficient and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff and the facilities. CalOptima monitors and maintains oversight of the Transplant Program.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM, the Clinical Performance Excellence Committee, identified stakeholders and reported to UMC. The UMC reviews the Over/Under Utilization Dashboard on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization. Over/under utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions
- Bed days
- Admits per 1000
- Average length of stay
- Readmission rates
- Denial rates
- Pharmacy utilization measures
- Appeal overturn rates — provider per 1,000 per year
- Member grievances per thousand
- Outliers from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures

- PCP and specialist referral pattern analysis
- Member utilization patterns
- Trends in UM-related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.
Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates areas of dissatisfaction, CalOptima develops an action plan and interventions to improve the areas of concern, which may include staff retraining and member/provider education.

20224
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

2021 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Himmet Dajee, M.D. **Date**

~~Utilization Management~~ Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Chair:

_____ _____

Supervisor Andrew Do **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. ~~Our 25th anniversary serving our members is in 2020.~~ We believe that our Medicaid (Medi-Cal) and Medicare members deserve ~~the highest~~ quality care and service ~~throughout~~ across the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

To ~~provide members with access to quality health care services delivered in a cost effective and compassionate manner~~serve member health with excellence and dignity, respecting the value and needs of each person.

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health. ~~To be a model public agency and community health plan that provides an integrated and well- coordinated system of care to ensure optimal health outcomes for all members.~~

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.
- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In ~~late~~ 2019, CalOptima's Board and executive team worked together to develop ~~our next three-year~~the 2020–2022 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is ~~unusual in that it is~~ both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. ~~Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population~~

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ~~ACA~~ Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

~~Under our Medi-Cal program,~~ CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's ~~services~~ Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that ~~went into effect~~began in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (HCA).
- Substance use disorder services are administered by HCA.
- Dental services are provided through ~~California's Denti-Cal program~~the Medi-Cal Dental Program.

Members with Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering ~~OneCare (OC)~~OC to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County~~,~~ and not be eligible for OCC. Enrollment in OC is by member choice and voluntary. ~~OneCare~~OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. [CM1][GV2][RJ3]Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral~~,~~ and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

Scope of Services
In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal. The demonstration program will end on December 31, 2022, and members in OCC will transition to OC.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits, and ~~an out of the country~~worldwide urgent/emergency care benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need~~,~~ when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with ~~our~~ members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-~~-~~Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be

enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Improve Health Equity and Mitigate Impact: COVID-19 Public Health Emergency (COVID-19 PHE)

COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2022~~2~~1 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy. Additionally, UM requirements for COVID-19 PHE screening, ~~vaccinates~~ vaccination and COVID-19 PHE related care are waived during the PHE. Also, authorizations approved during the PHE have been and will continue to be updated until the end of the COVID-19 PHE.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in ~~October 2020~~September 2021 revealed that Latinx account for ~~61.1~~45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7~~8~~% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as ~~laid out~~detailed in its QI Work Plan. ~~Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021 QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.~~

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 Draft CQS lays out DHCS' quality and health equity strategy to support a 10~~ten~~-year vision for ~~the~~ Medi-Cal ~~program~~, where people served by Medi-Cal should have longer, healthier~~,~~ and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM), and stresses DHCS' commitment to health equity, member involvement, and accountability in all program and initiatives.

~~Quality~~[GG4] ~~Strategy Goals~~Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and patient-centered chronic disease management
- Providing whole person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency accountability, and member involvement

~~Quality/~~Health Equity ~~Improvement~~ Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' ~~multi-pronged~~multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparity[GV5][GV6]

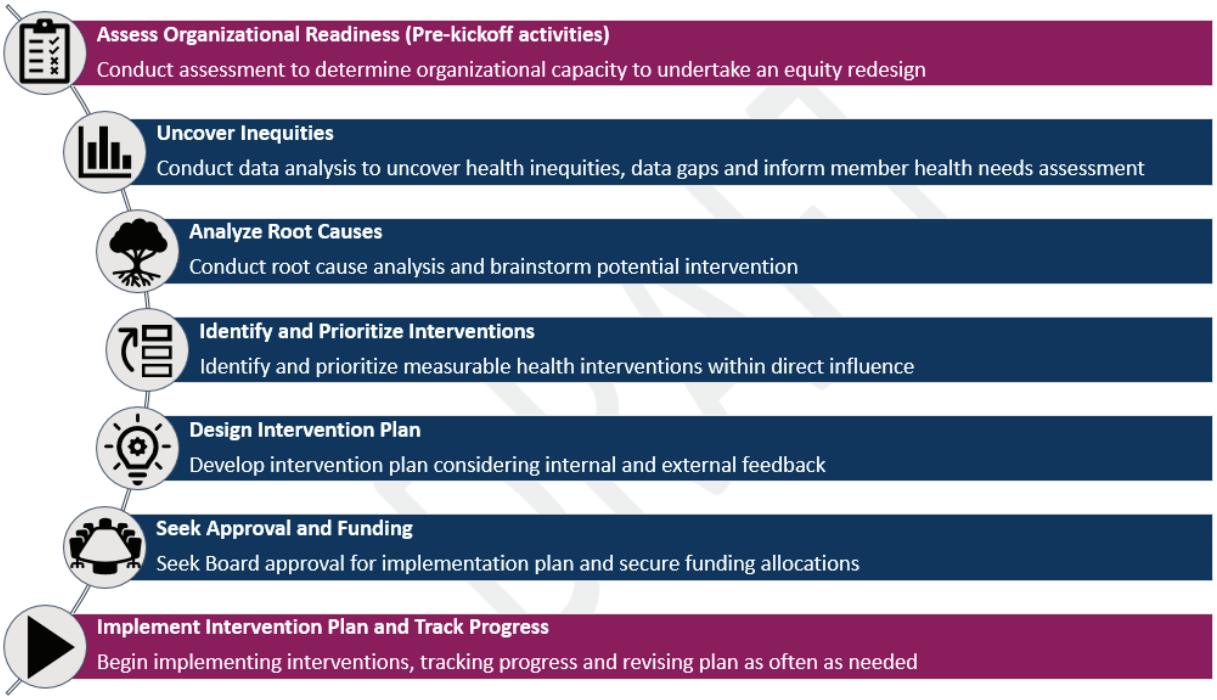
Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." (Centers for Disease Control and Prevention)

Social determinants of health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship, and age that affect health outcomes. (Henry J. Kaiser Family Foundation)

In response to CalOptima' strategic plan, staff began the process to identify and address health equity and social determinants of health (SDOH) for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes, designing comprehensive intervention plan, to planning and tracking progress. -It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. -As the framework is developed, there will be opportunities to obtain

feedback from internal and external stakeholders and include their input in the intervention and design process.



~~Whole-Person Care~~

~~Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information sharing platform was launched in November 2018. WPC is scheduled to terminate December 31, 2020; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicare Services (CMS) extend the pilot for an additional year~~.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with HCA.

~~Health Homes Program~~

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest-risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC, who are also eligible for the HHP, to continue with their current WPC providers for their housing- related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community connections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the county. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with Whole-Person Care and Board of Director's authorization to extend the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole Person Care program. The grant funds have been exhausted.

- ~~Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 PHE, these services are available via telehealth, in addition to in-person.~~
- ~~Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. CalOptima provides preventive screenings, chronic care, care coordination and follow up.~~
- ~~Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.~~

California Advancing and Innovating Medi-Cal (C~~AL~~alAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a ~~multi-year~~multiyear initiative, spanning from 2022 to 2027, by ~~the Department of Health Care Services (~~DHCS~~)~~ to improve the quality of life and health outcomes of our population by implementing broad delivery system, ~~as well as~~ program and payment~~,~~ reforms across Medi-Cal.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing ~~Social Determinants of Health~~social determinants of health.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

~~-~~Enhanced Care Management and Community Supports

~~Beginning on~~On ~~-~~January 1, 2022, CalOptima ~~will~~ implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. ~~Enhanced Care Management ECM~~ECM ~~-~~provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services~~,~~ ~~which~~that addresses the member's complex medical and social needs.~~-~~ Community Supports ~~provide a~~are alternatives to covered services, which are provided to reduce or avoid admissions to ~~substitute to, or to avoid, other covered services, such as~~ a hospital

or skilled nursing facility admission, emergency department visits, and ~~of a~~ discharge delays.

CalOptima's implementation of ECM and Community Supports ~~will~~ builds upon the Health Homes Program (HHP) and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima's HHP Community-Based Care Management Entities ~~will~~have transitioned to become ECM ~~P~~providers. This means that CalOptima and its delegated health networks (HNs) ~~will provide~~are providing ECM services as ECM providers to eligible populations. ~~Enhanced Care ManagementECM Providers~~ECM providers ~~will be~~are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

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
7. Coordination of and Referral to Community and Social Support Services

~~Beginning,~~On January 1, 2022, ECM ~~goes~~went live for the following populations of focus:

- Members experiencing h~~H~~omelessness (adults and children)
- High utilizer adults
- Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)
- (NEED TO REFERNCE JUSTICE INVOLVED???)

Additionally, members participating in WPC and/or HHP will automatically transition into ECM.

~~Health Homes Program and Whole-Person CareHHP and WPC~~HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand its network of Community Supports providers that have the expertise and capacity to provide the specific types of services~~, as~~ needed. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:

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 (Home Modifications)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

Beginning January 1, 2022, CalOptima will offer the following four, distinct Community Supports services:

1. Housing Transition Navigation Services
2. Housing Deposits

3. Housing Tenancy and Sustaining Services
4. Recuperative Care

CalOptima will continue to assess the needs the members and collaborate with community stakeholders to add new Community Supports.

2021 – 2022 CCNCalOptima Community Network (CCN) Pilot Program – Diabetes Mellitus (DM) Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics

To address high rates of poorly controlled diabetics identified in the CCN network, the following pilot program was proposed and approved by the CalOptima bBoard.

1. Pharmacist Involvement and Intervention
   CalOptima Pharmacist'ss' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dietietians/case managers.
2. Health Coach/Registered Dietietian Management Intervention
   CalOptima Health Coaches will provide CCN-focused interventions, such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dietietians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.
3. Non-Monetary Member Incentives
   CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.
4. Provider Incentives
   In order to have successful provider buy-ins, CalOptima proposes providingoffering provider incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective April 1, 2021January 1, 2022, the Department of Health Care Service (DHCS) is carving outcarved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed- care plans and moving moved it to the a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/-prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect the OneCare, or OneCare Connect and lines of business and or PACE Program.

~~Virtual Care Strategy~~

~~In 2021, federal and state rules and regulations provided limited waivers for telehealth due to the COVID-19 PHE, that enabled CalOptima to accelerate its virtual care strategy under COVID-19 PHE shelter-at-home measures. Members were able to receive appropriate health care services through telephone and video visits. CalOptima plans to continue expanding implementation of various virtual care strategies to improve member access to care with the following guiding principles in mind:~~

1. ~~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.~~
2. ~~Leverage existing delivery model where possible.~~
3. ~~Be proactive in seeking out opportunities to innovate.~~
4. ~~Provide technology-agnostic solutions.~~

~~Elements of the virtual care strategies will be shared at QIC and tracked as part of the QI Work Plan. With these virtual care strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits such as:~~

1. ~~Improved member access and convenience.~~
2. ~~Reduced avoidable in-person visits to specialists.~~
3. ~~Decreased wait time for specialty visits by members.~~

~~CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care such as improved member experience, augmented network capacity and adequacy, and improved clinical quality outcomes.~~

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering p~~P~~atient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM 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 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as 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. Additionally,

CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.

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. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs[RJ7]. Quality Initiatives for 2021~~0~~ are tracked in the QI Work Plan and reported to the QIC.

In 2021, the PHM Strategy ~~will be~~was focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as a public health issue~~s~~ in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.

The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined.
- Have specific objectives and timelines.
- Specify responsible departments and individuals.
- Be evaluated for effectiveness.
- Be tracked by QIC.

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, will be developed and implemented.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs providing health care to ~~Orange County's Medi-Cal~~CalOptima members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 1~~3~~2 HNs, representing more than ~~8,500~~10,000 practitioners.

CalOptima Direct (COD)

CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

- CalOptima Direct-Administrative (COD-A)

  CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations~~, who are not HN eligible~~, including dual-~~eligibles~~eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, newly eligible members transitioning to a ~~health network~~HN ~~on~~from ~~CNN~~CCN, and members residing outside of Orange County.~~-~~

- CalOptima Community Network (CCN)

  The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima ~~Direct-Administrative (COD-A)~~Contracted Health Networks

CalOptima has contracts with delegated HNs ~~-~~through a variety of ~~HN financial~~ risk models to provide care to members. The following contract risk models are currently in place~~s. Since 2008, CalOptima's HNs consist of~~:~~-~~

- Health Maintenance Organization~~s~~ (HMO~~s~~)
- Physician/Hospital Consortia (PHC~~s~~)
- Shared-Risk ~~Risk~~ ~~Medical~~ Group~~s~~ (SRG~~s~~)

Through our~~the~~ delegated ~~se~~ HNs, CalOptima members have access to ~~nearly~~ 1,5~~6~~00 primary care providers (PCPs), more than ~~6,800~~8,900 specialists, 4~~0~~1 hospitals, 3~~5~~4 clinics and ~~100~~99 long-term care facilities.~~-~~[CM8][RJ9]

CalOptima contracts with the following HNs:

~~CalOptima Direct Administrative is a self-directed program administered by CalOptima to serve Medi-~~

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect Medical Group		SRG	
AMVI Care Health Network	PHC		PHC
Optum Care Network - Arta ~~Western Medical Group~~	SRG	SRG	SRG
CHOC Health Alliance	PHC		
~~Family Choice Health Network~~	~~PHC~~		
Family Choice Medical Group	PHC	SRG	SRG
HPN-Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Optum Care Network - Monarch ~~HealthCare~~	HMO	SRG	HMO
~~Monarch Health Plan, Inc.~~	~~HMO~~		~~HMO~~
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Health Plan	HMO		HMO
Optum Care Network - Talbert ~~Medical Group~~	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

~~Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN-eligible.~~

~~CalOptima Community Network (CCN)~~

~~The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for members to select, supplementing the HN delivery model and creating additional capacity for access.~~

~~CalOptima Contracted Health Networks~~

~~CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:~~

- ~~Health Maintenance Organizations (HMOs)~~
- ~~Physician/Hospital Consortia (PHCs)~~

- ~~Shared Risk Medical Groups (SRGs)~~

~~Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.~~

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization m~~M~~anagement
- Basic and complex c~~C~~ase mManagement ~~and Complex Case Management~~
- Claims ~~(professional and institutional)~~
- Contracting
- Credentialing of practitioners
- Customer services ~~activities~~

MEMBERSHIP DEMOGRAPHICS[RJ10]

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2022

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

Membership Data from November 30, 2021, Financial Information

Total CalOptima Membership
867,182

Program	Members
Medi-Cal*	849,616
OneCare Connect	14,877
OneCare (HMO SNP)	2,274
Program of All-Inclusive Care for the Elderly (PACE)	415

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
27%	6 to 18
33%	19 to 44
18%	45 to 64
12%	65+

Languages Spoken (All Programs)

59%	English
26%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

41%	Temporary Assistance for Needy Families
35%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
5%	People with Disabilities
<1%	Long-Term Care
<1%	Other

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership

808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.

* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. -Additionally, access to appropriate services, providers~~,~~ and care settings.~~–~~ The UM Program ~~incorporates~~incorporates physical and behavioral health, pharmacy services, and post-~~-~~stabilization care across all care settings. ~~all care settings~~This includes ~~including~~ preventive, emergency, primary, specialty, ~~behavioral health,~~ home- and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care and pharmacy services in accordance with state and federal laws, regulations, contract requirements, NCQA standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability~~,~~ and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on ~~Medical~~ medical ~~Necessity~~ necessity and/or benefit coverage.
- Identify and refer high-need~~risk~~ members to Case Management programs, including Complex and Enhanced Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify and report potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify and address over- and underutilization of services~~issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services~~.
- Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- Promote improved member health and well-being by coordinating services with appropriate

county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.

- Educate, monitor and evaluate practitioners and other providers, including delegated HNs on delivery of CalOptima's UM Program, policies and procedures on an ongoing basis.
- ~~Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.~~
- Provide c~~C~~ontinuous identification of UM staff needs, and appropriate training delivered to address those needs, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to ~~assure~~ ensure that the member receives appropriate, ~~cost~~ cost-efficient, quality--based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), ~~and~~ NCQA and established be~~a~~st practice standards/benchmarks at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is overseen ~~evaluated on an ongoing basis for efficacy and appropriateness of content~~ by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the ~~;~~ Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains ~~accountability~~accountabilities for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit ~~and~~ & Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs' UM activities by the Audit ~~and~~ & Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA, and CalOptima standards and program requirements.
- Annual approval of the delegate's UM ~~program~~ Program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation ~~adjustments~~review, or de-delegation.

LONG-TERM SUPPORT SERVICES

CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute: Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.
- In April 2020, all LTC member facility clinical reviews and medical necessity nursing facility visits were suspended due to the COVID-19 PHE. All clinical review is now performed electronically and telephonically.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and ~~persons~~ peopel with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT). In April 2020, all CBAS member and facility clinical reviews and medical necessity visits were suspended due to the ~~Public Health Emergency~~ COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically.
- MSSP: Home- and community-based care coordination of a wide range of services and

equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. Starting in April 2020, all MSSP member and facility clinical reviews and medical necessity visits were suspended due to the COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically.

Behavioral Health Services

Medi-Cal
CalOptima offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Services include but are not limited to individual and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima also covers Alcohol Misuse Screening and Counseling (AMSC) services provided to members 18 and older in the primary care setting.

CalOptima covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavior~~al~~ analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

Most mental health services do not require a physician referral. Members may access mental health services~~,~~ by calling the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

OC and OCC
CalOptima offers the following mental health services to OC and OCC members:

- Outpatient mental health care including but not limited to individual and group psychotherapy, medication management, psychological testing, intensive outpatient program (IOP), and partial hospitalization program (PHP).
- Inpatient mental health care in either a psychiatric or general hospital.
- Opioid Treatment Program (OTP) services.
- Alcohol Misuse Screening and Counseling (AMSC) services.

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination

of the member's impairment level. If the member has mild to moderate impairments, the member will be offered behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima directly manages all administrative functions of the OC and OCC behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's state and federal ~~Contracts~~ contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The Board ~~promotes~~ ensures the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) ~~is comprised of~~has 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation~~,~~ and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership ~~is composed of~~has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- Consumer
- Family Support

- Foster Children
- Long-Term Care Representative
- Medi-Cal Beneficiaries
- Medical Safety Net Representative
- Orange County Health Care Agency (standing seat)
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

~~- Adult beneficiaries~~
~~- Children~~
~~- Consumers~~
~~- Family support~~
~~- Foster children~~
~~- HCA~~
~~- LTSS~~
~~- Medi-Cal beneficiaries~~
~~- Medically indigent persons — medical safety net~~
~~- Orange County Social Services Agency (SSA)~~
~~- Persons with disabilities~~
~~- Persons with mental illnesses~~
~~- Persons with special needs — behavioral/mental health~~
~~- Recipients of CalWORKs~~
~~- Seniors~~

~~Two of the 15 positions — held by HCA and SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.~~

OneCare Connect Member Advisory Committee
The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and ~~is comprised of~~has 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership ~~is comprised of~~has representatives from the following constituencies:
- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities~~.~~
- HCBS representative serving seniors~~.~~
- HCBS representative serving members from an ethnic or cultural community~~.~~
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:

- HCA, Behavioral Health
- SSA
- OC Community Resources Agency, Office on Aging
- OC IHSS Public Authority

~~The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.~~

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. ~~The PAC is comprised of providers who~~PAC members represent a broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets at least quarterly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) when it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC ~~is composed of the following~~has 11 voting seats:

- Family representatives: seven ~~to nine~~ seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are current recipients of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services.
- Interests of children representatives: ~~two to~~ four seats
  - Community-based organizations; or
  - Consumer advocates

~~Members of the committee shall serve staggered two-year terms. WCM FAC meets at least quarterly and meetings are open to the public.~~

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO)~~,~~ oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies~~,~~ and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, ~~Case~~ Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM), makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The EDCO is expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED of Clinical Operations,

supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. ~~Reporting to the ED of Q&PHM are the Directors of Quality Analytics, Quality Improvement, Population Health Management, Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.~~

Medical Directors have primary assigned roles but may provide coverage and back up to other specialties as needed. ~~-~~All medical directors are ~~, **Utilization Management** is~~ appointed by the CMO and/or DCMO and are~~is~~ responsible to adhere to and oversee ~~for~~ the direction of the UM Program and ~~-~~ objectives~~, ,~~ as well as evaluation of the UM Program.

- The medical director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and ~~utilizes~~ uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. The medical director p~~P~~rovides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the ~~bi-weekly~~biweekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

- The m~~M~~edical d~~D~~irector~~, Behavioral Health~~ who oversees the ~~is the designated~~ behavioral health program is a participating member ~~care practitioner in the QI and UM programs who serves as a participating member~~ of the UMC, QIC and CPRC. The medical director provides consultation and oversight to the UM ~~p~~Program, including guidance on criteria review and development to ensure parity. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

- The m~~M~~edical d~~D~~irector who oversees specialty programs and services~~, Senior Programs~~ is a key member of the medical management team and is responsible for the Medi-Medi programs ~~(OC and OCC), ,~~ MLTSS programs, and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments~~. I~~, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program ~~for~~of All-Inclusive Care for the Elderly (PACE) Center.

~~The medical director works in collaboration with the other medical directors and the clinical staff within PHM, GARS, and Provider Relations. The medical director works closely with the nursing and non-clinical leadership of these departments.~~

~~Medical Director, Population Health Management, Health Education, Program for All Inclusive Care for the Elderly (PACE) is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, disease management and health education programs, while also providing clinical quality oversight of the PACE Center.~~

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in ~~Utilization Management (~~UM~~)~~ departmental operations. This position ~~will~~ provide~~s~~ leadership and direction to the ~~Utilization Management~~UM department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's UM ~~program~~ Program for CalOptima Community Network, CalOptima Direct and the delegated HNs. ~~-~~The Director is expected to serve as a liaison for various internal and external committees, workgroups~~,~~ and operational meetings.

Director, Behavioral Health Services ~~(Integration)~~ is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM ~~program~~Program. The director tracks, analyzes~~,~~ and reports to senior staff on changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and BH care services. ~~-~~The director is responsible for the day-to-day operation of the program overseeing a team of care managers, medical case managers and medical authorization assistants who support all BH UM functions. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, ~~legal counsel,~~ state and federal officials, and representatives of other agencies.

~~**Director, Behavioral Health Services (Clinical Operations)** is responsible for the day-to-day operation of the BH UM program. The director oversees a team of care managers, medical case managers and medical authorization assistants who support all BH UM functions. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.~~

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data analytical direction to support quality measurement activities for the ~~agency-wide~~agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. ~~Provides~~ This position provides coordination and support to the QIC and other committees to support compliance with regulatory~~,~~ and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for ~~agency-wide~~agencywide population health initiatives~~.~~ ~~Ensures~~ while ensuring linkages supporting a whole-~~-~~person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position p~~P~~rovides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees

to support compliance with regulatory and accreditation agency requirements.

Director~~(s)~~, Audit ~~and~~ & Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The director~~s~~ ensures that CalOptima and ~~its~~ subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the ~~directors~~ director leads~~lead~~ the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director~~s~~ is ~~are~~ responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. ~~These positions~~The position interacts with the Board of Directors, CalOptima executives, departmental management, HN management and legal counsel.

RESOURCES

UM Resources

The following staff positions provide support for the UM department's organizational/operational functions and activities:

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements~~,~~ and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

~~Experience & Education~~

- ~~Current and unrestricted RN or LVN license in the State of California.~~
- ~~A Bachelor's degree or relevant experience in a health care field preferred.~~
- ~~5 years varied clinical experience required.~~
- ~~3 years managed care experience.~~
- ~~2-3 years supervisory/management experience in UM activities.~~

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

~~Experience & Education~~

- ~~Current and unrestricted RN or LVN license in the State of California.~~
- ~~A Bachelor's degree or relevant experience in a health care field preferred.~~
- ~~3 years managed care experience preferred.~~
- ~~Supervisor experience in Managed Care/UM preferred.~~

Manager, Utilization Management (Prior Authorization [PA])~~,~~ manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

~~Experience & Education~~
- ~~Current and unrestricted RN or LVN license in the State of California.~~
- ~~A Bachelor's degree or relevant experience in a health care field preferred.~~
- ~~5 years varied clinical experience required.~~
- ~~3 years managed care experience.~~
- ~~2–3 years supervisory/management experience in UM activities.~~

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the ~~member's~~ member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

~~Experience & Education~~
- ~~Current and unrestricted RN license or LVN license in the State of California.~~
- ~~A Bachelor's degree or relevant experience in a health care field preferred.~~
- ~~3 years managed care experience.~~
- ~~Supervisor and/or Lead experience in Managed Care/UM preferred.~~

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

~~Experience & Education~~
- ~~Current and unrestricted California Board LVN or CA RN license.~~
- ~~A Bachelor's degree or relevant experience in a health care field preferred.~~
- ~~3 years managed care experience.~~

- Excellent analytical and communication skills required.

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs, and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- Current and unrestricted California Board LVN or RN license.
- Minimum 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case. Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- High school graduate or equivalent; a minimum 2 years of college preferred.
- 2 years related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.

Experience & Education
- High school diploma or equivalent; a minimum 2 years of college preferred.
- 2–3 years previous administrative experience preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

Monitoring Nurses – UM (Medical Care Manager (LVN)) provide monitoring of referrals and specific UM initiatives to ensure compliance with UM requirements. Monitoring activities include monitoring referrals including inpatient and outpatient, WCM, findings on Correction Action Plans (CAPs) from both internal and external audits, as well as identify opportunity for improvement when identified during the monitoring process.

Experience & Education
- Current and unrestricted California Board LVN or RN license.
- Minimum 3 years current clinical experience.

- ~~Excellent telephone skills required.~~
- ~~Computer literacy required.~~
- ~~Excellent interpersonal skills.~~

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements~~,~~ and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

~~Experience & Education~~

- ~~A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.~~
- ~~American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.~~
- ~~Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.~~

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, research, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T) Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

~~Experience & Education~~

- ~~A current, valid, unrestricted California state Pharmacy License and Pharm.D required.~~
- ~~At least 3 years' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.~~
- ~~Current knowledge and expertise in clinical pharmacology and disease states required.~~
- ~~Basic working knowledge of the Medi-Cal or Medicaid programs preferred.~~
- ~~ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.~~

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima delegated health plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling,

member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

~~Experience & Education~~

- ~~A current, valid, unrestricted California state Pharmacy License and Pharm.D required.~~
- ~~3 years' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.~~
- ~~Current knowledge and expertise in clinical pharmacology and disease states required.~~
- ~~Basic working knowledge of the Medi-Cal or Medicaid programs preferred.~~
- ~~ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.~~

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

~~Experience & Education~~

- ~~Pharm.D degree from an accredited college of pharmacy.~~
- ~~Eligibility for licensure in California.~~

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, -and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring ~~high~~ high-quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

~~Experience & Education~~

- ~~Bachelor's degree in Nursing or in a related field required.~~
- ~~Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.~~
- ~~5–7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.~~
- ~~Some experience in government or public environment preferred.~~
- ~~Experience in the development and implementation of new programs.~~

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS ~~department's~~ department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for ~~CalOptima's~~ CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational~~,~~ and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

~~Experience & Education~~

- ~~A current and unrestricted RN license in the State of California.~~
- ~~A Bachelor's degree or relevant experience in a health care field preferred.~~
- ~~5–7 years varied clinical experience required.~~
- ~~3–5 years supervisory/management experience in a managed care setting and/or nursing facility.~~
- ~~Experience in government or public environment preferred.~~
- ~~Experience in health care with geriatrics and persons with disabilities.~~

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner.

The ~~position's~~ position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the ~~department's~~ department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

~~Experience & Education~~

- ~~A current unrestricted RN license in the State of California.~~
- ~~A Bachelor's degree or relevant experience in a health care field preferred.~~
- ~~3 years varied experience at a health plan, medical group, or skilled nursing facilities required.~~
- ~~Experience in interacting/managing with geriatrics and persons with disabilities.~~
- ~~Supervisory/management experience in UM activities.~~
- ~~Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.~~

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice~~,~~ responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and act~~s~~ as liaisons to Orange County ~~based~~ community agencies, CBAS centers, skilled nursing facilities, members and providers.

~~Experience & Education~~

- ~~A current and unrestricted RN license or LVN license in the State of California.~~
- ~~Minimum 3 years managed care or nursing facility experience.~~
- ~~Excellent interpersonal skills.~~
- ~~Computer literacy required.~~
- ~~Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.~~

Program Manager, LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department, specifically with regard to operational and regulatory reports. The ~~incumbent will: (~~manager 1) lead~~s~~ collaborative efforts as an LTSS liaison, educator and coach with the CBAS centers, LTC Nursing Facilities, MSSP and the IHSS program to meet regulatory compliance procedures; ~~(~~2) work~~s~~ with the LTSS Manager to lead the implementation and ongoing maintenance of the LTSS program policies and desktop procedures to ensure reporting requirements are met; ~~(~~3) gather~~s~~ and validate~~s~~ LTSS data to submit for DHCS reporting requirements and CalOptima QI Program; ~~(~~4) work~~s~~ with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; ~~(~~5) support~~s~~ long-term departmental sustainability efforts; and ~~(~~6) ~~all~~ completes other activities related to the development and implementation of the LTSS program.

~~Experience & Education~~

- ~~Bachelor's degree in Sociology, Psychology, or Gerontology is required.~~
- ~~Master's degree in Social Work, Public Health, Gerontology, Health Care Administration, Public Policy, or other related field preferred.~~
- ~~5+ years of program development experience.~~
- ~~Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.~~
- ~~Previous work experience in managing programs and building relationships with community partners is preferred.~~
- ~~Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers, LTC facilities and community events.~~

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

~~Experience & Education~~

- ~~Master's degree in Behavioral Health or other related degree is required.~~
- ~~A current and unrestricted Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) license in the State of California required, Licensed Psychologist is preferred.~~
- ~~4 years supervisor or manager level experience required.~~
- ~~1 year experience in behavioral health audits (including CMS, DHCS, Department of Managed Health Care [DMHC] and NCQA).~~
- ~~1 year experience in developing policies and procedures to meet federal and state regulatory requirements.~~
- ~~1 year experience in developing sound and responsible business plans and financial models preferred.~~

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services ~~(Integration)~~, Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

~~Experience & Education~~

- ~~Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.~~
- ~~4 years of experience working in a managed care environment, with specific experience in BH UM.~~
- ~~4 years of supervisor or manager level experience required.~~
- ~~Experience in a government or public environment strongly preferred.~~
- ~~2 years' experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.~~

- ~~2 years' experience and aptitude for working in a highly matrixed, mission-driven organization required.~~

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The ~~Supervisor~~ supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT ~~""~~"best practice"~~""~~ guidelines. The ~~Supervisor~~ supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

~~Experience & Education~~
- ~~Master's degree in Behavioral Health or other related degree is required.~~
- ~~Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.~~
- ~~3 or more years of supervisor level experience in clinical management of ABA services is required.~~
- ~~3 or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.~~

Medical Case Managers (BH-RN) are responsible for reviewing and processing authorization requests for inpatient and outpatient behavioral health services. Medical Case Managers adhere to CalOptima's prior authorization approval process, which includes reviewing authorization requests for medical necessity and ~~consult~~ consulting with managers and CalOptima medical directors as needed. The position is responsible for learning and utilizing CalOptima's medical criteria, UM criteria, and related policies/procedures for authorization and referral requests from BH and ABA providers.

~~Experience & Education~~
- ~~Current and unrestricted RN license to practice in the State of California.~~
- ~~Minimum 3 years current BH clinical experience or an equivalent combination of education and experience required.~~
- ~~Active Certified Case Manager (CCM) certification preferred.~~
- ~~Experience in a prior authorization and/or managed care environment preferred.~~
- ~~Experience with inpatient concurrent review strongly preferred.~~

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. The manager uses~~Utilizes~~ medical criteria, and policies and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers.

~~Experience & Education~~
- ~~High school diploma required, Associates or bachelor's degree in related field preferred.~~
- ~~Current and unrestricted LVN license to practice in the State of California required~~
- ~~3 years clinical experience required.~~
- ~~Inpatient behavioral health experience preferred.~~
- ~~Active CCM certification preferred.~~

Care Manager is responsible for the oversight and review of BHT services offered to members that

meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

~~Experience & Education~~
- ~~Master's degree in BH or another related field is required.~~
- ~~Board Certified Behavioral Analyst (BCBA) or Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.~~
- ~~4 or more years providing ABA therapy to children diagnosed with ASD is required.~~
- ~~Experience in clinical, medical utilization review, and/or quality assurance is preferred.~~
- ~~Bilingual in English and in one of CalOptima's defined threshold languages is preferred.~~

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

~~Experience & Education~~
- **~~High school diploma or equivalent is required.~~**
- **~~Bachelor's degree in BH or related field is preferred.~~**
- **~~2 years' experience in BH, community services, or other social services setting required.~~**
- **~~Experience in working with children diagnosed with ASD.~~**
- **~~Customer/member services experience preferred.~~**
- **~~HMO, Medi-Cal/Medicaid and health services experience preferred.~~**
- **~~Driver's license and vehicle or other approved means of transportation may be required for some assignments.~~**
- **~~Bilingual in English and in one of CalOptima's defined threshold languages is preferred.~~**

Qualifications and Training

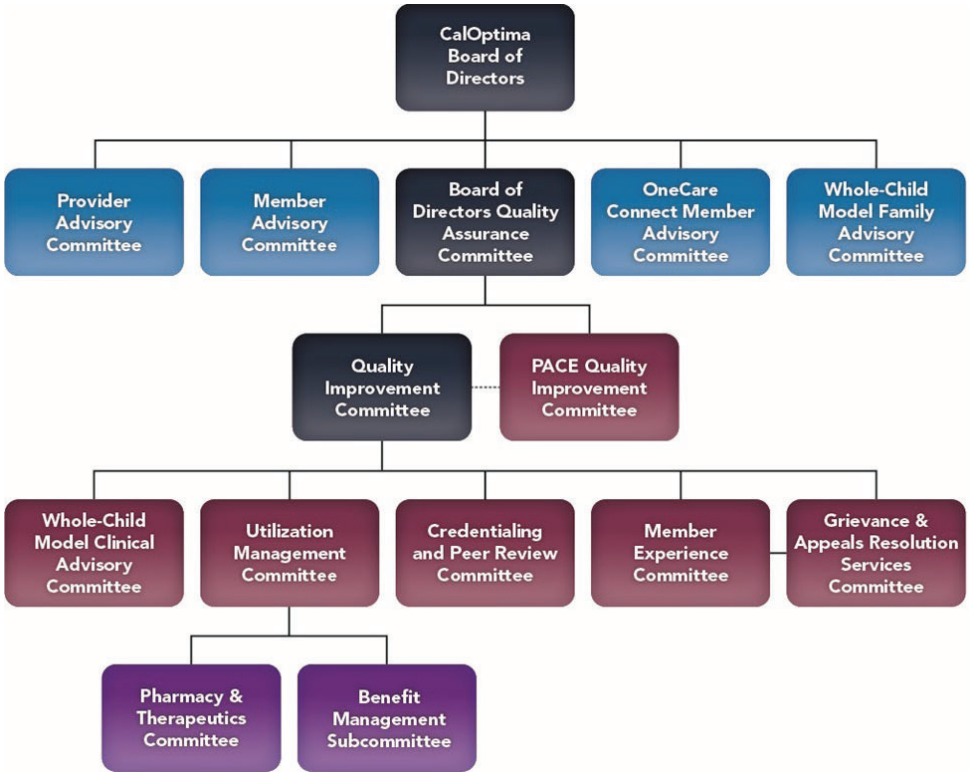
CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:
- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training
- OC and OCC Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff are required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents~~,~~ or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.



UMC

The UM Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs~~,~~ and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM ~~program~~ Program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC, which reports up to QIC and ultimately to QAC and the Board of Directors.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM

~~program~~Program, consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HNs.

- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM ~~program~~ Program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses~~,~~ and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals.
  - UM Workgroup
  - LTSS

- Reports to the QIC on a quarterly basis~~;~~, communicates significant findings and makes recommendations related to UM issues.

UMC Membership

Voting Members:

- CMO
- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees ~~Senior~~ Specialty Programs
- Medical Director who oversees Whole-Child Model Program
- ~~Medical Director Quality and Analytics~~
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned

to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Director, UM
- ~~Medical Director, Whole Child Model~~
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director who oversees ~~,~~UM services ~~Utilization Management~~ — Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets ~~at least six times per year~~quarterly, at minimum, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM ~~program~~ Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or underutilization is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during

utilization review activities. These issues are referred to the QI staff for evaluation.

- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, LTSS Programs, P&T, QI, Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process ~~utilizes~~ uses quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments.

Conflict of Interest

CalOptima maintains a ~~Conflict of Interest~~Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the department of compliance and assigned privacy officer. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs and SRGs hold all information in the strictest confidence. Members of the QIC and the subcommittees sign a Confidentiality Agreement. This agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

UM Process

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization inpatient services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit & Oversight department via its delegation oversight team for compliance.

Review and Authorization of Services

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances appropriate clinical criteria and CalOptima polices, applying current evidence-based guidelines, and consideration of available services within the local delivery system on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessarily means all covered services or supplies that:

- For Medi-Cal, covered services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal members under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d® and California Welfare and Institutions Code sections 14132(v).
- For children under 21, Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illness conditions may be approved under Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
- For Medicare, covered services that are reasonable and necessary for 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 section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization ~~inpatient~~ review
- Concurrent/Continued Stay Review for selected conditions~~.~~
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure ~~GG.1508: Authorization and Processing of Referrals~~CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time~~-~~frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with

timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services in accordance with CalOptima Policy and Procedure HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process.~~.~~

- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service authorization request; for OC/OCC all member notifications as listed above and notice of approval.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request~~.~~
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior ~~authorization~~ Authorization requires the provider or practitioner to submit a formal medical

necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima ~~Link system~~Provider Portal allows for non-urgent ~~on line~~online authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of-~~-~~network practitioners.

Second Opinions
A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-~~-~~network ~~practitioner, if~~practitioner if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "CalOptima policy and procedure, GG.1112: Standing Referral to Specialist Practitioner or Specialty Care Center, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests ~~a provider~~an out-of-network provider for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise~~, and complexity of the case.~~

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the OneCare/Connect (OC/OCC) Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations

Medi-Cal

Effective ~~April 1, 2021~~January 1, 2022, the outpatient pharmacy benefit ~~will move~~moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

~~OC/OCC~~Medi-Cal/Medicare

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM

follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

BEHAVIORAL HEALTH DETERMINATIONS

Medi-Cal
CalOptima's BH~~I~~ department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, DHCS All Plan Letters (APL)~~,~~ and CalOptima policy (approved by DHCS).

Medi-Cal/Medicare
~~**OC/OCC**~~
CalOptima has previously delegated Magellan Health Inc. to directly manage the BH UM functions for OneCare/OneCare Connect. [RJ11]Effective January 1, 2020, CalOptima's BHI department performed prior authorization review functions for OC/OCC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL)~~,~~ and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed CalOptima Psychologist or Medical Director. ~~CalOptima's~~ CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time-frames and the ~~member's~~ member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM CRITERIA

CalOptima conducts Utilization Review using UM criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM

criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:[RJ12]

Medi-Cal

1. Federal and State Law Mandates (i.e., Department of Health Care Services — Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
    a. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

2. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

3. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)

4. Other: US Preventative Services Task Force, Guideline Central
    a. https://www.uspreventiveservicestaskforce.org/
    b. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and CCS Program Information Notices for decisions related to CCS and Whole-Child Model.
    a. https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

2. Follow Medi-Cal hierarchy listed above.

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates – CMS, DMHC
    a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
        i. https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

2. Department of Health Care Services
    a. Medi-Cal Provider Manual
    b. http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

3. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
    a. https://www.nccn.org/professionals/physician_gls/default.aspx

4. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
    a. https://www.guidelinecentral.com/library/

5. CalOptima Policy and Procedures and/or Clinical Benefits and Guidelines

Delegated HNs must utilize Medi-Cal & Medicare Guidelines, Title 22, and national evidenced based guidelines.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Attachment A
TIMEFRAMES FOR MEDI-CAL

Authorization Types

Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse ~~Reviewer~~**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG, updated annually-/-Medi-Cal and Medicare Manuals-/-CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG-/-Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Diagnostics	MCG-/-Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Hearing Aids	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Home Health	MCG-/-Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Imaging	MCG-/-Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals/~~-~~CCS Numbered Letters for WCM	X	X	X
Injectables	MCG-/-Medi-Cal and Medicare Manuals		X	X
Inpatient Hospital Services	MCG-/-Medi-Cal and Medicare Manuals/~~-~~CCS Numbered Letters for WCM		X	X
Medical Supplies (DME Related)	MCG-/-Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X ~~X~~	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG-/-Medi-Cal and Medicare Manuals	X ~~X~~	X	X

Office Visits (Follow-up)	MCG-/-Medi-Cal and Medicare Manuals	X ~~X~~	X	X
Orthotics	MCG-/-Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters for WCM	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG-/-Medi-Cal and Medicare Manuals/~~/~~CCS Numbered Letters for WCM		X	X
Prosthetics	MCG-/-Medi-Cal and Medicare Manuals/~~/~~CCS Numbered Letters for WCM		X	X
Radiation Oncology	MCG-/-Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG-/-Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	
Transplants	DHCS Guidelines/-MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria, and no clinical judgment is required.

** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director-/ Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-–Term Care Services-/-Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-–Term Care Services-/-Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-–Term Care Services-/-Title 22, CCR, Sections 51003 and 51303		**X**	**X**

Long-Term Care: Intermediate Care Facility-/-Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-–Term Care Services-/-Title 22, CCR, Sections 51343 and 51164	**X** DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care-/-Title 22, California Code of Regulations	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Director-/-Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer-/ Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	**X**		**X**
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an

annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability
At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the Committee.

Provider and Member Communication
Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **711**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned on the next business day and communications received after midnight on Monday–Friday are responded to on the same business day.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g., sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima. In cases requiring immediate response the vendor staff notifies CalOptima on-call nurse. CalOptima will review and process authorizations outside business hours, as necessary, including decisions to deny or modify authorization requests which are made by CalOptima on-call UM physician. A log is forwarded by the vendor to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer
The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM

process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care[RJ13], our UM system.

UM Staff Access to Clinical Expertise

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, have the authority, accountability, and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective and concurrent review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member
CalOptima's UM ~~program~~ Program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for -
providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

Attachment A
TIMEFRAMES FOR MEDI-CAL

UM Decision and Notification Timelines

Medi-Cal (Excludes Pharmacy Requests)[RJ14]

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

Attachment A

TIMEFRAMES FOR MEDI-CAL

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 [BJ15][SM16]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

Attachment A
TIMEFRAMES FOR MEDI-CAL

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 72 hour 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.

Attachment A
TIMEFRAMES FOR MEDI-CAL

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 Request. **Member:** Within 30 days of receipt of request

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.

Attachment B

TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect

Medicare

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.

~~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.

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.

~~Attachment B~~

~~TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect~~

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 request.

~~Attachment B~~

~~TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect~~

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.

~~Standard Initial Organization Determination (Pre~~	~~As soon as medically indicated, within a maxi of 14 calendar days after~~	~~Within 14 calendar days after rec of request.~~
~~Standard Initial Organization Determination (Pre Service)~~ ~~If extension request or needed~~	~~May extend up to 14 calendar days. Note: Extension allowed *only* if member requests or the provider / organization justifies a need for additi information and is able t demonstrate how the del in the interest of the mem~~	~~Extension Notice:~~ ~~Give notice in writing within 14 calendar days of receipt of reques The extension notice must include~~ ~~• The reasons for the delay~~ ~~The right to file an expedited~~

Expedited Initial Organization Determination **If expedited criteria not met**	**Promptly decide whether expedite.** **determine if:** 1. **Applying the standa timeframe could seriousl jeopardize the life or hea of the member or the member's ability to regai maximum function, or** 2. **If a physician (contracted or non-**	**If request is not deemed to be expedited, give the member prom (within 72 hours) oral notice of the denial of expedited status includin the member's rights followed by written notice within 3 calendar d of the oral notice.** **The written notice must include:** 1. **Explain that the health plan automatically transfer and proces**

Expedited Initial Organization Determination **If no extension requested or neede**	**As soon as medically necessary, within 72 hou after receipt of request (includes weekends and holidays).**	**Within 72 hours after receipt of request.** **▪ Approvals** **○ Oral or written notice must b given to member and provider wi 72 hours of receipt of request.** **○ Document date and time ora**

Expedited Initial Organization Determination **If extension request or needed**	**May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additi information and is able t demonstrate how the del in the interest of the mem (for example, the receipt additional medical evide from non-contracted providers may change a decision to deny). Extens must not be used to pend organization determinati while waiting for medica records from contracted providers.**	**Extension Notice:** **Give notice in writing, within 72 h of receipt of request. The extensio notice must include:** **▪ The reasons for the delay** **▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to gran extension.** **▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt.**

	▪ Documentation of th attempt within 24 hours not replace the requirem to send the written Exten	

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal	OC and OCC

Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager Qualified pharmacist or physician rev for any modifications or denials Qualified physician review for any appeals	Processed by CalOptima Pharmacy Management Department Qualified pharmacist or physician review any modifications or denials Qualified physician review for any appeal

Medi-Cal	OC and OC-C

Standard (Non-urgent) Pre-Sservice: Within 24 hours a **decision to approve, modify, deny or defer is required.** **Standard (Non-urgent) Pre-Sservice, Extension Needed:** **Within 5 working days of receiving needed information,** **but no longer than 14 calendar days** **Expedited (Urgent) Pre-Sservice/Concurrent: Within 24** **hours a decision to approve, modify, or defer is.** **required.** **Expedited (Urgent) Pre-Sservice/Concurrent, Extension** **Needed: Within 72 hours of the initia request**	**Routine**[SM17][RJ18]**: 72 hours** **Urgent: 24 hours** **Retrospective: 14 days**

Medi-Cal	OC and OCC
Pre-Service and Concurrent Approv	Authorization Request Type:
Provider: Electronic/written: Within hours of making the decision. Pre-Service and Concurrent Denials: Provider: Electronic/written: Within hours of making the decision. Member: Written: Within 2 business days of making the decision. Post Service/ Retrospective Approval	For expedited requests: Written notification must be provided to t member within 24 hours from the receipt of the request. I initial notification is made orally, then written notification m be provided within 3 calendar days of the oral notificat For standard requests: Written notification must be provided to t member within 72 hours from the receipt of the request. If ir notification is made orally, then written notification mus provided within

Emergency Services

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

A non-contracted hospital must submit a Prior Authorization Request for Post-Stabilization Services when a member who has received emergency services for an emergency medical condition is determined to have reached medical stability, but requires additional, medically necessary inpatient covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition. -The attending emergency physician, or the ~~P~~provider treating the ~~M~~member, is responsible for determining when the ~~M~~member is sufficiently stabilized for transfer or discharge.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) do not apply to contracted providers ~~relative to~~in CalOptima's Medi-Cal ~~Program~~program. CalOptima or a HN shall approve or deny a prior authorization request for post-stabilization services and all information reasonably necessary and requested to render a decision from a non-contracted hospital within 30 minutes after receiving such request and information for Medi-Cal members, and within 60 minutes after receiving such request and information from a non-contracted hospital for OC or OCC members. If CalOptima or the HN does not respond within the prescribed time-frame, medically necessary post-stabilization inpatient services are considered approved.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director of UM, or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director~~,~~ of UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of ~~post~~ post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

Contracted f~~F~~acilities are required to notify CalOptima of all inpatient prior-authorized admissions within one (1) business day following the actual admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed~~.~~
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care~~.~~
- Additional days/service/procedures proposed~~.~~
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent

concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time-frame appropriate for the type of decision (i.e., pre-service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins ~~within 48 hours~~at the time of an inpatient admission and is designed to identify and initiate a safe, ~~cost~~ cost-effective, ~~quality~~ quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort ~~between~~ among the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a ~~member's~~ member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate ~~multi-disciplinary~~multidisciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations

by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial~~,~~ or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time-frames as noted in CalOptima Policy GG.150~~8~~7: Notification Requirements for Covered Services Requiring Prior Authorization~~Authorization and Processing of Referrals~~. The written notification is written in lay language that is easily understandable at the ~~6th~~ sixth grade level and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time-frames for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

GRIEVANCE AND APPEAL PROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, OC or OC-C members wish to exercise their right to review the UM decision to deny, delay~~,~~ or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative~~,~~ or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in ~~the~~ gathering ~~of~~ information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues ~~is~~ are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service department.

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Fair Hearing

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a

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State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC and OCC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider- preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

LONG-TERM SERVICES AND SUPPORTS

LTC

The LTC case management program includes authorizations for the following facilities:

- NF-A, NF-B, ~~sub-acute~~subacute care

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: On-site NFs where CalOptima nurses make monthly or ~~bi-monthly~~bimonthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to assess a member's needs through review of the Minimum Data Set, ~~member's~~ member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for on-site only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when a member needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff through monthly on-site visits, quarterly and annual

workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS
An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP
CalOptima has responsibility for the payment of MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons people 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs;, case management;, money management and counseling;, respite;, housing assistance;, assistive devices;, legal services;, transportation;, nutrition services;, home health care;, meals;, personal care assistance with hygiene;, personal safety;, and activities of daily living.

TRANSITIONS OF CARE

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from acute care hospitals (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a PHR to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family

members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the current Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician~~,~~ and facilities are assisted in order to assure timely, efficient~~,~~ and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff~~,~~ and the facilities. CalOptima monitors and maintains oversight of the Transplant Program.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM, the Clinical Performance Excellence Committee, identified stakeholders and reported to UMC. The UMC reviews the Over/Under Utilization Dashboard on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization. ~~-~~Over/~~- and U~~u~~nder ~~U~~u~~tilization~~ monitoring and performance are reported to the QIC and QAC on a quarterly basis.

The following are measures tracked and monitored for over/under utilization trends:

- ER admissions

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- Bed days
- Admits per 1000~~.~~
- Average length of stay
- Readmission rates
- Denial rates
- Pharmacy utilization measures
- Appeal overturn rates — provider per 1,000 per year
- Member grievances per thousand
- Outliers from Fraud, Waste ~~&~~ and Abuse investigations
- Select HEDIS rates for selected measures~~.~~
- PCP ~~&~~ and specialist referral pattern analysis
- Member utilization patterns
- Trends in ~~UM~~ UM-related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified~~.~~

PROGRAM EVALUATION

The UM Program is evaluated at least annually~~,~~ and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing~~,~~ and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers~~,~~ and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.
Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys

with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates ~~that there are~~ areas of dissatisfaction, CalOptima develops an action plan and interventions to improve ~~on~~ the areas of concern, which may include staff retraining and member/provider education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
14. Approve Modifications to Policy GG.1101: California Children's Services (CCS)/Whole-Child Model (WCM) – Coordination with County CCS Program

Contacts
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Action
Approve modifications to CalOptima Utilization Management Policy GG.1101: California Children's Services (CCS)/Whole-Child Model (WCM)– Coordination with County CCS Program.

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. The updates to the policy reflect the changes to the WCM program dictated by DHCS in APL 20-005.

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).

Policy GG.1101: California Children's Services (CCS)/Whole-Child Model (WCM)– Coordination with County CCS Program.

Policy Section	Change
II. B.	Updated referenced All Plan Letter (APL) to APL 21-005 (Revised)
II. E. 1. A., b.	Updated to include authorization responsibilities for CalOptima or a Health Network
II. F. 1. A., b.	Added requirements for CCS program eligibility determination
II. F. 3	Added process for the Medical Therapy Unit (MTU) to submit referrals to CalOptima
III. B., C., 1, 2, 3.	Added specifics to the referral of potential CCS eligible members to the County CCS program
III. G., H, and I.	Added required reporting of NICU acuity assessment and High Risk Infant Follow-up (HRIF) to the County CCS program and coordination of transition services for those WCM members who lose Medi-Cal eligibility
III. R.	Added requirements for major organ transplants (MOT) of WCM members

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Fiscal Impact

The recommended action to approve changes to GG.1101 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.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program (Redline)

/s Michael Hunn *04/28/2022*
Authorized Signature **Date**

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Policy:	GG.1101
Title:	**California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	/s/
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a Health Network and the County California Children's Services (CCS) program.

II. POLICY

A. CalOptima is responsible for California Children's Services (CCS) program--eligible Members who have transitioned into the WCM program, newly CCS-eligible members, or new CCS members enrolling in CalOptima, including the identification and referral of Members with CCS-~~eligible~~Eligible Conditions.

B. With respect to the WCM program, CalOptima and the Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as the California DHCS guidance, including, but not limited to, All Plan Letter (APL) ~~18-023:~~21-005 (Revised): California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the Health Networks shall:

1. Use all current and applicable CCS program guidelines, including CCS program statutes, regulations, CCS program information notices, and CCS numbered letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-~~eligible~~Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the County CCS program for the coordination of CCS services to Members.

D. At least quarterly, CalOptima shall convene a ~~quarterly~~ meeting between CalOptima and the ~~local~~County CCS program in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services~~/~~ Whole--Child Model.

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E. CalOptima or a Health Network shall assume responsibility for the WCM program as follows:

1. Authorization and payment of CCS-eligible medical services, including authorization activities, claims processing and payment, Case Management, and quality oversight and coordination of all Medi-Cal and CCS-covered services, as well as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), for enrolled Members. This shall include, but may not be limited to:

   a. Authorization activities for Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU) and referrals arising from Medical Therapy Conference, Medical Therapy Program (MTP), and Medical Therapy Unit (MTU) that are not otherwise the responsibility of the MTU; and

   b. Responsibility for NICU acuity assessment, authorization, and payment function activities in Orange County.

2. Providing all supporting medical documentation and information needed for CCS annual medical eligibility redetermination and other medical determinations.

3. Providing all Member information in a Transfer Packet to the County CCS program to facilitate inter-county transfer in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services~~/~~ Whole-Child Model.

4. High Risk Infant Follow-Up (HRIF) program, including ~~determining~~determination of HRIF program eligibility, ~~coordinating~~coordination, and ~~authorizing~~authorization of HRIF services for Members in accordance with CCS N.L. 05-1016: High Risk Infant Follow-Up (HRIF) Program Services, or any superseding CCS N.L., and ensuring the provision of HRIF Case Management services in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services~~/~~ Whole~~-~~Child Model.

F. County CCS ~~Program~~program WCM responsibilities~~,~~ include but are not limited to:

1. CCS program eligibility determination~~,~~ including ~~responding~~:

   a. Obtaining any additional information (*e.g.*, medical reports) required to complete annual redeterminations;

   b. As part of the CCS eligibility review, reviewing and determining MTP eligibility, if applicable; and

   ~~a.~~c. Responding to and tracking appeals related to CCS program medical eligibility determinations and redeterminations~~; and~~.

2. Care coordination for ~~Medical Therapy Program (~~MTP~~)~~ services, receiving and processing referrals to the MTP (except for review and authorization of durable medical equipment, including custom and specialized durable medical equipment, and related supplies), physical and occupational therapy services provided at the ~~Medical Therapy Units (MTU),~~MTUs, medical therapy conference services, and financial assistance to Members under the age of twenty-one (21) who are eligible for MTP.

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3. The MTP shall submit referrals to CalOptima for Medically Necessary specialty services and follow-up treatment, as prescribed by the MTU conference team physician.

~~3.~~4. Notify CalOptima of a new CCS-eligible inter-county transfer Member via a Transfer Packet.

G. DHCS WCM responsibilities include but are not limited to:

1. Review and final determination of unresolved disagreements between CalOptima and the County CCS program relative to CCS medical eligibility.

H. If a Member has Other Health Coverage (OHC), CalOptima or a Health Network shall consider the OHC plan as the Member's primary health plan. CalOptima or a Health Network shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

~~I.~~H. ~~CalOptima or a Health Network shall proactively coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the County CCS program for ongoing health care and Case Management services.~~

~~1. CalOptima or a Health Network shall notify the County CCS program in writing, within fifteen (15) calendar days, of CCS-eligible neonates, infants, and children up to three (3) years of age, that lose Medi-Cal coverage.~~

III. PROCEDURE

A. A Practitioner shall perform appropriate baseline health assessments and diagnostic evaluations to identify potential CCS-~~eligible~~Eligible Conditions in accordance with CalOptima Policy GG.1116: Pediatric Preventive Services.

B. CalOptima or a Health Network shall provide:

1. Training and resources to Primary Care Physician and other Primary Care Providers (PCP) to ensure timely identification of Members with potential CCS-~~eligible~~Eligible Conditions and notification to the County CCS program;

2. Provision and payment of Medically Necessary Covered Services related to the identification, evaluation, and diagnosis of a CCS-~~eligible~~Eligible Condition;

3. Medically Necessary Covered Services whether related or unrelated to a Member's CCS-~~eligible~~Eligible Condition;

4. Authorization and reimbursement of only CCS-paneled physicians and CCS-approved facilities for the treatment of CCS-~~eligible~~Eligible Conditions, in accordance with CCS program requirements and CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

5. CalOptima or a Health Network shall identify Members who may have a CCS-~~eligible~~Eligible Condition through various means, including but not limited to:

a. Screening of all requests for service authorizations for Medi-Cal Members under the age of twenty-one (21) by a trained team of nurses and medical authorization assistants;

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b. Screening of all Members referred for Case Management, Disease Management, and/or Population Health Management services or who are currently enrolled in a Case Management, Disease Management, or Population Health Management program; and

c. Review of pharmacy data.

C. CalOptima shall refer a Member to the County CCS program for initial and annual medical eligibility determination after identifying that the Member's medical condition may qualify him or her for CCS. Such referral of potential CCS-eligible Members shall also be made if the Members:

1. Demonstrate potential CCS-Eligible Condition(s) as outlined in the CCS Medical Eligibility Guide, including Members who are suspected of having possible CCS-Eligible Condition(s) resulting from diagnostic services or who are undergoing diagnostic services for CCS;

2. Present at the emergency department, provider, or facility for other primary conditions, and demonstrate potential CCS-Eligible Condition(s); or

3. Are potentially MTP eligible.

D. A Health Network shall refer a Member for initial and annual CCS medical eligibility determination through CalOptima, as described in Section III.C. of this Policy, by:

1. Completing a Service Authorization Request (SAR) form and submitting the request to CalOptima; and

2. Ensuring the submission of all supporting medical documentation and information needed to determine CCS medical eligibility and to determine the Medical Necessity of the services requested.

3. CalOptima shall facilitate the CCS medical eligibility determination by the County CCS program by submitting the New Referral CCS GHPP Client Service Authorization Request (SAR) and supporting medical documentation to the County CCS program.

E. CalOptima shall refer a Member to the County CCS program within twenty-four (24) hours, or the next working day, after determining that the Member may have a CCS-~~eligible~~Eligible Condition, as described in Section III.D. of this Policy.

F. CalOptima, a Health Network, or a Practitioner shall refer all Members, including new Members, newly CCS-eligible Members, and WCM transition Members who may have developed a new CCS-Eligible Condition, immediately to CalOptima for transmittal to the County CCS program for CCS eligibility determination, as set forth in Section III.D. of this Policy, and not wait until the annual CCS medical eligibility determination period.

G. CalOptima shall report to the County CCS program all Members identified as meeting the criteria for the NICU acuity assessment in order to capture the CCS referral.

1. To ensure accurate and complete reporting to the County CCS program, Health Networks shall report their respective assigned Members identified as meeting the criteria for NICU acuity assessment to CalOptima in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

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2. CalOptima or a Health Network, as applicable, shall review authorizations and determine if services meet CCS NICU requirements for their respective assigned Member.

H. CalOptima shall report to the County CCS program all Members identified as HRIF in order to capture the CCS referral.

1. To ensure accurate and complete reporting to County CCS program, Health Networks shall report their respective assigned Members identified as HRIF to CalOptima in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

I. CalOptima or a Health Network shall proactively coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the County CCS program for ongoing health care and Case Management services.

1. CalOptima or a Health Network shall notify the County CCS program in writing of CCS-eligible neonates, infants, and children up to three (3) years of age, that lose Medi-Cal coverage for HRIF services. Such notification shall occur as soon as CalOptima or a Health Network is made aware, but no later than fifteen (15) calendar days of being made aware, of its assigned Member no longer having Medi-Cal eligibility.

J. The County CCS program will provide confirmation or adverse determination of CCS medical eligibility to CalOptima in accordance with CCS program eligibility requirements.

1. CalOptima shall ensure notification of the CCS medical eligibility determination to the requesting Health Network within twenty-four (24) hours of receipt of the County CCS program CCS medical eligibility determination.

K. Disagreements between CalOptima and the County CCS program regarding CCS medical eligibility determinations must be resolved by the County CCS program, in consultation with DHCS. The ~~local~~County CCS program shall communicate all resolved disputes in writing to CalOptima in a timely manner. Disputes between CalOptima and the County CCS program that are unable to be resolved will be referred by either entity to DHCS.

L. Members appealing a CCS eligibility determination must appeal to the County CCS program.

M. Member Grievances

1. CalOptima shall ensure Members are provided information on and are provided the same grievances, appeals and state fair hearing rights as provided under state and federal law and in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1108: State Hearing Process and Procedures, and GG.1510: ~~Appeals~~Appeal Process.

N. Provider Grievances

1. CalOptima or a Health Network shall address and resolve CCS provider complaints, including but not limited to disputes or grievances concerning the processing of a payment or non-payment of a claim by CalOptima or Health Network in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint. CalOptima or a Health Network shall communicate the resolution process to all of its CCS providers.

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O. CalOptima or a Health Network shall proactively coordinate services for a WCM Member reaching twenty-one (21) years of age, including but not limited to those Members eligible for services with the Genetically Handicapped Persons program (GHPP), in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services~~/~~ Whole-Child Model.

P. CalOptima or a Health Network shall ensure the development of an Individual Care Plan (ICP), Case Management, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services~~/~~ Whole-Child Model.

Q. CalOptima or a Health Network shall ensure access to out-of-network providers for eligible Members in order to obtain Medically Necessary services in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

R. CalOptima or a Health Network shall ensure the provision of all Medically Necessary major organ transplants for CCS-eligible Members and shall refer a CCS-eligible Member to a CCS-approved Specialty Care Center for an evaluation within seventy-two (72) hours of the Member's PCP or specialist identifying the CCS-eligible Member as a potential candidate for a Major Organ Transplant in accordance with CalOptima Policies GG.1105: Coverage of Organ and Tissue Transplants and GG.1508: Authorization and Processing of Referrals.

~~R.~~S. CalOptima or a Health Network shall ensure the provision of the Maintenance and Transportation benefit for CCS-eligible Members ~~and a~~or the Member's family seeking transportation to a medical service related to the Member's CCS-~~eligible~~Eligible Condition in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

~~S.~~T. CalOptima and its Health Network shall provide appropriate preventive, mental health, developmental, and specialty EPSDT medical services under the scope of the CalOptima program to eligible children under age twenty-one (21) years in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

~~T.~~U. CalOptima shall ensure oversight of the functions and responsibilities, processes, and performance of a Health Network, including compliance with the requirements of the WCM program and network adequacy standards in accordance with CalOptima Policies GG.1619: Delegation Oversight and GG.1600: Access and Availability Standards.

IV. ATTACHMENT(S)

A. Application to Determine CCS Program Eligibility
B. New Referral CCS GHPP Client Service Authorization Request (SAR)

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
D. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model
E. Department of Health Care Services (DHCS) CCS Medical Eligibility Guide
~~E.~~F. CalOptima Policy FF.2003: Coordination of Benefits

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G. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
~~F.~~H. CalOptima Policy GG.1116: Pediatric Preventive Services
~~G.~~I. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~H.~~J. CalOptima Policy GG.1330: Case Management – California Children's Services~~/~~ Whole-Child Model
~~I.~~K. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~J.~~L. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~K.~~M. CalOptima Policy GG.1510: ~~Appeals~~Appeal Process
~~L.~~N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
~~M.~~O. CalOptima Policy GG.1547: Maintenance and Transportation
~~N.~~P. CalOptima Policy GG.1600: Access and Availability Standards
~~O.~~Q. CalOptima Policy GG.1619: Delegation Oversight
~~P.~~R. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~Q.~~S. CalOptima Policy HH.1102: Member Grievance
~~R.~~T. CalOptima Policy HH.1108: State Hearing Process and Procedures
U. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
~~S.~~V. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services
W. CCS Numbered Letter 03-0421: California Children's Services Program Whole Child Model (Revised)
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-005 (Revised): California Children's Services Whole Child Model Program (Supersedes APL 18-023~~: California Children's Services Whole Child Model Program~~)
~~T.~~Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and MMCE Provisions of CalAIM
~~U.~~Z. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
~~V.~~AA. Welfare and Institutions Code §§14093.06(b) and 14094.15(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
11/02/2018	Department of Health Care Services (DHCS)	Approved as Submitted
03/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
12/19/2019	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTIONS

Date	Meetings
10/04/2018	Regular Meeting of the CalOptima Board of Directors
10/03/2019	Regular 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
Effective	05/01/1999	GG.1101	California Children's Services	Medi-Cal
Revised	05/01/2000	GG.1101	California Children's Services	Medi-Cal
Revised	04/01/2007	GG.1101	California Children's Services	Medi-Cal
Revised	08/01/2009	GG.1101	California Children's Services	Medi-Cal

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Action	Date	Policy	Policy Title	Program
Revised	09/01/2014	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2015	GG.1101	California Children's Services	Medi-Cal
Revised	10/01/2016	GG.1101	California Children's Services	Medi-Cal
Revised	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	10/04/2018	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Reinstated	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	10/03/2019	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Revised	10/01/2020	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Revised	TBD	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
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.
California Children's Services ~~eligible~~ (CCS)-Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to ~~members~~Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Case Management	A systematic approach to coordination of care for a ~~member~~Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Continuity of Care	Services provided to a ~~member~~Member rendered by an out-of-network provider with whom the ~~member~~Member has pre-existing provider relationship.
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 ~~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.

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Term	Definition
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.
Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any ~~medically necessary~~Medically Necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
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~~Covered Services to ~~members~~Members assigned to that Health Network.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Maintenance	The cost(s) for lodging (such as motel room, etc.) and food for the ~~member~~Member, parent(s), or legal guardian(s) when needed to enable the ~~member~~Member to access authorized services for a CCS-Eligible Condition.
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.

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Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, 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.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a ~~member~~Member, for the payment of the reasonable value of all or part of the health care benefits provided to a ~~member~~Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Population Health Management (PHM)	A model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions.
Practitioner	A licensed independent ~~practitioner~~Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing ~~covered services.~~Covered Services.

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Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to members and serves as the medical home for members. The PCP is a general ~~practitioner~~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 program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic.
Primary Care Provider (PCP)	~~A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility~~A person responsible for supervising, coordinating, and providing initial and ~~primary care~~Primary Care to Members ~~and serves as~~; for initiating referrals; and, for maintaining the ~~medical home for Members~~continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Transportation	For purposes of this Policy, the cost(s) for the use of a private vehicle or public conveyance to provide the ~~member~~Member access to authorized services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy:	GG.1101
Title:	**California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the guidelines for coordination of care between CalOptima or a Health Network and the County California Children's Services (CCS) program.

II. POLICY

A. CalOptima is responsible for California Children's Services (CCS) program-eligible Members who have transitioned into the WCM program, newly CCS-eligible members, or new CCS members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions.

B. With respect to the WCM program, CalOptima and the Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as the California DHCS guidance, including, but not limited to, All Plan Letter (APL) 21-005 (Revised): California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima and the Health Networks shall:

1. Use all current and applicable CCS program guidelines, including CCS program statutes, regulations, CCS program information notices, and CCS numbered letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.

C. CalOptima shall enter into a memorandum of understanding (MOU), or other agreement, with the County CCS program for the coordination of CCS services to Members.

D. At least quarterly, CalOptima shall convene a meeting between CalOptima and the County CCS program in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services Whole-Child Model.

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E. CalOptima or a Health Network shall assume responsibility for the WCM program as follows:

1. Authorization and payment of CCS-eligible medical services, including authorization activities, claims processing and payment, Case Management, and quality oversight and coordination of all Medi-Cal and CCS-covered services, as well as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), for enrolled Members. This shall include, but may not be limited to:

   a. Authorization activities for Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU) and referrals arising from Medical Therapy Conference, Medical Therapy Program (MTP), and Medical Therapy Unit (MTU) that are not otherwise the responsibility of the MTU; and

   b. Responsibility for NICU acuity assessment, authorization, and payment function activities in Orange County.

2. Providing all supporting medical documentation and information needed for CCS annual medical eligibility redetermination and other medical determinations.

3. Providing all Member information in a Transfer Packet to the County CCS program to facilitate inter-county transfer in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Whole-Child Model.

4. High Risk Infant Follow-Up (HRIF) program, including determination of HRIF program eligibility, coordination, and authorization of HRIF services for Members in accordance with CCS N.L. 05-1016: High Risk Infant Follow-Up (HRIF) Program Services, or any superseding CCS N.L., and ensuring the provision of HRIF Case Management services in accordance with CalOptima Policy GG.1330: Case Management - California Children's Services Whole-Child Model.

F. County CCS program WCM responsibilities include but are not limited to:

1. CCS program eligibility determination including:

   a. Obtaining any additional information (*e.g.*, medical reports) required to complete annual redeterminations;

   b. As part of the CCS eligibility review, reviewing and determining MTP eligibility, if applicable; and

   c. Responding to and tracking appeals related to CCS program medical eligibility determinations and redeterminations.

2. Care coordination for MTP services, receiving and processing referrals to the MTP (except for review and authorization of durable medical equipment, including custom and specialized durable medical equipment, and related supplies), physical and occupational therapy services provided at the MTUs, medical therapy conference services, and financial assistance to Members under the age of twenty-one (21) who are eligible for MTP.

3. The MTP shall submit referrals to CalOptima for Medically Necessary specialty services and follow-up treatment, as prescribed by the MTU conference team physician.

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4. Notify CalOptima of a new CCS-eligible inter-county transfer Member via a Transfer Packet.

G. DHCS WCM responsibilities include but are not limited to:

1. Review and final determination of unresolved disagreements between CalOptima and the County CCS program relative to CCS medical eligibility.

H. If a Member has Other Health Coverage (OHC), CalOptima or a Health Network shall consider the OHC plan as the Member's primary health plan. CalOptima or a Health Network shall remain the secondary health plan and payer of last resort in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

III. PROCEDURE

A. A Practitioner shall perform appropriate baseline health assessments and diagnostic evaluations to identify potential CCS-Eligible Conditions in accordance with CalOptima Policy GG.1116: Pediatric Preventive Services.

B. CalOptima or a Health Network shall provide:

1. Training and resources to Primary Care Physician and other Primary Care Providers (PCP) to ensure timely identification of Members with potential CCS-Eligible Conditions and notification to the County CCS program;

2. Provision and payment of Medically Necessary Covered Services related to the identification, evaluation, and diagnosis of a CCS-Eligible Condition;

3. Medically Necessary Covered Services whether related or unrelated to a Member's CCS-Eligible Condition;

4. Authorization and reimbursement of only CCS-paneled physicians and CCS-approved facilities for the treatment of CCS-Eligible Conditions, in accordance with CCS program requirements and CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

5. CalOptima or a Health Network shall identify Members who may have a CCS-Eligible Condition through various means, including but not limited to:

a. Screening of all requests for service authorizations for Medi-Cal Members under the age of twenty-one (21) by a trained team of nurses and medical authorization assistants;

b. Screening of all Members referred for Case Management, Disease Management, and/or Population Health Management services or who are currently enrolled in a Case Management, Disease Management, or Population Health Management program; and

c. Review of pharmacy data.

C. CalOptima shall refer a Member to the County CCS program for initial and annual medical eligibility determination after identifying that the Member's medical condition may qualify him or her for CCS. Such referral of potential CCS-eligible Members shall also be made if the Members:

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1. Demonstrate potential CCS-Eligible Condition(s) as outlined in the CCS Medical Eligibility Guide, including Members who are suspected of having possible CCS-Eligible Condition(s) resulting from diagnostic services or who are undergoing diagnostic services for CCS;

2. Present at the emergency department, provider, or facility for other primary conditions, and demonstrate potential CCS-Eligible Condition(s); or

3. Are potentially MTP eligible.

D. A Health Network shall refer a Member for initial and annual CCS medical eligibility determination through CalOptima, as described in Section III.C. of this Policy, by:

1. Completing a Service Authorization Request (SAR) form and submitting the request to CalOptima; and

2. Ensuring the submission of all supporting medical documentation and information needed to determine CCS medical eligibility and to determine the Medical Necessity of the services requested.

3. CalOptima shall facilitate the CCS medical eligibility determination by the County CCS program by submitting the New Referral CCS GHPP Client Service Authorization Request (SAR) and supporting medical documentation to the County CCS program.

E. CalOptima shall refer a Member to the County CCS program within twenty-four (24) hours, or the next working day, after determining that the Member may have a CCS-Eligible Condition, as described in Section III.D. of this Policy.

F. CalOptima, a Health Network, or a Practitioner shall refer all Members, including new Members, newly CCS-eligible Members, and WCM transition Members who may have developed a new CCS-Eligible Condition, immediately to CalOptima for transmittal to the County CCS program for CCS eligibility determination, as set forth in Section III.D. of this Policy, and not wait until the annual CCS medical eligibility determination period.

G. CalOptima shall report to the County CCS program all Members identified as meeting the criteria for the NICU acuity assessment in order to capture the CCS referral.

1. To ensure accurate and complete reporting to the County CCS program, Health Networks shall report their respective assigned Members identified as meeting the criteria for NICU acuity assessment to CalOptima in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

2. CalOptima or a Health Network, as applicable, shall review authorizations and determine if services meet CCS NICU requirements for their respective assigned Member.

H. CalOptima shall report to the County CCS program all Members identified as HRIF in order to capture the CCS referral.

1. To ensure accurate and complete reporting to County CCS program, Health Networks shall report their respective assigned Members identified as HRIF to CalOptima in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

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I. CalOptima or a Health Network shall proactively coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the County CCS program for ongoing health care and Case Management services.

1. CalOptima or a Health Network shall notify the County CCS program in writing of CCS-eligible neonates, infants, and children up to three (3) years of age, that lose Medi-Cal coverage for HRIF services. Such notification shall occur as soon as CalOptima or a Health Network is made aware, but no later than fifteen (15) calendar days of being made aware, of its assigned Member no longer having Medi-Cal eligibility.

J. The County CCS program will provide confirmation or adverse determination of CCS medical eligibility to CalOptima in accordance with CCS program eligibility requirements.

1. CalOptima shall ensure notification of the CCS medical eligibility determination to the requesting Health Network within twenty-four (24) hours of receipt of the County CCS program CCS medical eligibility determination.

K. Disagreements between CalOptima and the County CCS program regarding CCS medical eligibility determinations must be resolved by the County CCS program, in consultation with DHCS. The County CCS program shall communicate all resolved disputes in writing to CalOptima in a timely manner. Disputes between CalOptima and the County CCS program that are unable to be resolved will be referred by either entity to DHCS.

L. Members appealing a CCS eligibility determination must appeal to the County CCS program.

M. Member Grievances

1. CalOptima shall ensure Members are provided information on and are provided the same grievances, appeals and state fair hearing rights as provided under state and federal law and in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeal Process.

N. Provider Grievances

1. CalOptima or a Health Network shall address and resolve CCS provider complaints, including but not limited to disputes or grievances concerning the processing of a payment or non-payment of a claim by CalOptima or Health Network in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint. CalOptima or a Health Network shall communicate the resolution process to all of its CCS providers.

O. CalOptima or a Health Network shall proactively coordinate services for a WCM Member reaching twenty-one (21) years of age, including but not limited to those Members eligible for services with the Genetically Handicapped Persons program (GHPP), in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Whole-Child Model.

P. CalOptima or a Health Network shall ensure the development of an Individual Care Plan (ICP), Case Management, care coordination, and risk stratification in accordance with CalOptima Policy GG.1330: Case Management – California Children's Services Whole-Child Model.

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Q. CalOptima or a Health Network shall ensure access to out-of-network providers for eligible Members in order to obtain Medically Necessary services in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

R. CalOptima or a Health Network shall ensure the provision of all Medically Necessary major organ transplants for CCS-eligible Members and shall refer a CCS-eligible Member to a CCS-approved Specialty Care Center for an evaluation within seventy-two (72) hours of the Member's PCP or specialist identifying the CCS-eligible Member as a potential candidate for a Major Organ Transplant in accordance with CalOptima Policies GG.1105: Coverage of Organ and Tissue Transplants and GG.1508: Authorization and Processing of Referrals.

S. CalOptima or a Health Network shall ensure the provision of the Maintenance and Transportation benefit for CCS-eligible Members or the Member's family seeking transportation to a medical service related to the Member's CCS-Eligible Condition in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

T. CalOptima and its Health Network shall provide appropriate preventive, mental health, developmental, and specialty EPSDT medical services under the scope of the CalOptima program to eligible children under age twenty-one (21) years in accordance with CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

U. CalOptima shall ensure oversight of the functions and responsibilities, processes, and performance of a Health Network, including compliance with the requirements of the WCM program and network adequacy standards in accordance with CalOptima Policies GG.1619: Delegation Oversight and GG.1600: Access and Availability Standards.

IV. ATTACHMENT(S)

A. Application to Determine CCS Program Eligibility
B. New Referral CCS GHPP Client Service Authorization Request (SAR)

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency
D. CalOptima Memorandum of Understanding with Orange County Health Care Agency for Whole Child Model
E. Department of Health Care Services (DHCS) CCS Medical Eligibility Guide
F. CalOptima Policy FF.2003: Coordination of Benefits
G. CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants
H. CalOptima Policy GG.1116: Pediatric Preventive Services
I. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
J. CalOptima Policy GG.1330: Case Management – California Children's Services Whole-Child Model
K. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
L. CalOptima Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Policy GG.1510: Appeal Process
N. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services

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O. CalOptima Policy GG.1547: Maintenance and Transportation
P. CalOptima Policy GG.1600: Access and Availability Standards
Q. CalOptima Policy GG.1619: Delegation Oversight
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy HH.1102: Member Grievance
T. CalOptima Policy HH.1108: State Hearing Process and Procedures
U. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
V. CCS Numbered Letter 05-1016: High Risk Infant Follow Up (HRIF) Program Services
W. CCS Numbered Letter 03-0421: California Children's Services Program Whole Child Model (Revised)
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-005 (Revised): California Children's Services Whole Child Model Program (Supersedes APL 18-023)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and MMCE Provisions of CalAIM
Z. Title 22, California Code of Regulations (CCR), §§41515.2 through 41518.9
AA. Welfare and Institutions Code §§14093.06(b) and 14094.15(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
11/02/2018	Department of Health Care Services (DHCS)	Approved as Submitted
03/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
12/19/2019	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTIONS

Date	Meetings
10/04/2018	Regular Meeting of the CalOptima Board of Directors
10/03/2019	Regular 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
Effective	05/01/1999	GG.1101	California Children's Services	Medi-Cal
Revised	05/01/2000	GG.1101	California Children's Services	Medi-Cal
Revised	04/01/2007	GG.1101	California Children's Services	Medi-Cal
Revised	08/01/2009	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2014	GG.1101	California Children's Services	Medi-Cal
Revised	09/01/2015	GG.1101	California Children's Services	Medi-Cal
Revised	10/01/2016	GG.1101	California Children's Services	Medi-Cal
Revised	11/01/2017	GG.1101	California Children's Services	Medi-Cal
Revised	10/04/2018	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Reinstated	11/01/2017	GG.1101	California Children's Services	Medi-Cal

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Action	Date	Policy	Policy Title	Program
Revised	10/03/2019	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Revised	10/01/2020	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal
Revised	TBD	GG.1101	California Children's Services (CCS)/Whole-Child Model - Coordination with County CCS Program	Medi-Cal

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IX. GLOSSARY

Term	Definition
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.
California Children's Services (CCS)-Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
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.

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Term	Definition
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.
Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any Medically Necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
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.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Maintenance	The cost(s) for lodging (such as motel room, etc.) and food for the Member, parent(s), or legal guardian(s) when needed to enable the Member to access authorized services for a CCS-Eligible Condition.
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.
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, 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.

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Term	Definition
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Population Health Management (PHM)	A model of care that strives to address patients' health needs at all points along the continuum of care, including the community setting, by increasing patient participation and engagement and targeting interventions.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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 program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialist or clinic.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Transportation	For purposes of this Policy, the cost(s) for the use of a private vehicle or public conveyance to provide the Member access to authorized services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form **or** whose out-of-pocket medical expenses for a child who qualifies are **expected** to be more than 20 percent of family income.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

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• Disorders of the skin and subcutaneous tissue (severe hemangioma)
• Medically handicapping malocclusion (severely crooked teeth)
Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

• complete the application form on page 3 and return it to their county CCS office;
• give CCS all of the information requested so CCS can determine if the family qualifies;
• apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

• CCS must keep this information confidential.[2]

• CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

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Notes
1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)
3 Section 123800 et. seq. of the California Health and Safety Code
4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

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APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. Please type or print clearly.

A. Applicant Information

1. Name of Applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by

2. Date of birth (month, day, year)	3. Place of birth - county and state	Country, if born outside the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

5. Gender	6. Race/Ethnicity	7. Social security number (optional)

8. What is the applicant's suspected eligible CCS condition or disability?

9. Primary Care Physician	10. Physician's phone number

B. Parent/Legal Guardian/Family Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name

13. Residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

14. Mailing address (if different from 13)	City	County	Zip Code

15. Home phone number	16. Cell phone number	17. Work phone number	18. What language do you speak at home?
( )	( )	( )	

19. Email address	20. Number of persons in family unit

21. Other Parent Name and Address if not living with the applicant

C. Health Insurance Information

22. Does the applicant have Medi-Cal? ☐ Yes ☐ No	23. If yes, what is the applicants Medi-Cal number?	24. Is there a share-of-cost? ☐ Yes ☐ No	25. If yes, what is the amount you pay per month? $

26a. Does the applicant have other health insurance? ☐ Yes ☐ No	26b. If yes, what is the name of the insurance plan or company?	26c. Policy or Plan Number

27. Type of insurance plan or company
☐ Preferred Provider Organization (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other: _____

28. Does the applicant have dental insurance? ☐ Yes ☐ No	29. Does the applicant have vision insurance? ☐ Yes ☐ No

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

_____I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of applicant by the CCS program.

_____I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

_____I certify that I have read and understand the information or have had it read to me.

_____I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date

Signature of witness (only if the person signed with a mark)	Date

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INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHCS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office. Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next Box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. Box.
5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).
6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

- Alaskan Native
- Amerasian
- American Indian
- Asian
- Asian Indian
- Black/African American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Hispanic/Latino
- Japanese
- Korean
- Laotian
- Samoan
- Vietnamese
- White
- Other

7. **Applicant's social security number *(optional)*:** Please write the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Write the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's primary care physician:** Write the name of the applicant's physician.
10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.
13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. Box.
14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.
15. **Home phone number:** Please write the home phone number where you can be reached.
16. **Cell phone number:** Please write the cell phone number where you can be reached.
17. **Work phone number:** Please write the work phone number where you can be reached.
18. **Language(s) spoken:** Write the language you speak **at home**.
19. **Email address**: Write the email address for the parent or legal guardian.
20. **Number of persons in family unit:** Write the number of persons living in the same household.

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21. **Other Parent Name and Address if not living with the applicant:** Write the name and address for a second contact person.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

22. If the applicant does not receive Medi-Cal, check "No" and go to number 26a. If the applicant receives Medi-Cal, check "Yes" and fill in the applicant's Medi-Cal number.

23. If you the applicant has Medi-Cal, enter the 14 digit Medi-Cal number.

24. If you pay a portion of the cost of your Medi-Cal insurance, check "Yes".

25. If you pay a portion of the chare of cost, fill in the monthly amount paid.

26a. If the applicant does not have other health insurance, check "No" and go to number 28.

26b. If the applicant has health insurance, fill in the name of the insurance plan or company.

26c. If the applicant has health insurance, fill in the policy or plan number.

27. If the applicant has health insurance, check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.

28. If the applicant has dental insurance, check "Yes." If the applicant does not have dental insurance, check "No."

29. If the applicant has vision insurance, check "Yes." If the applicant does not have vision insurance, check "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhcs.ca.gov/services/ccs or look in the government section of your local telephone directory under California Children's Services or county health department.

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NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)	City	State ZIP code
5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last	first	middle
9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)
12. CCS/GHPP case number	13. Medical record number (hospital or office)	14. Home phone number ( )
15. Cell phone number ( )	16. Work phone number ( )	17. Email address
18. Residence address (number, street) *(DO NOT USE P.O. BOX)*	City	State ZIP code
19. Mailing address (if different) (number, street, P.O. box number)	City	State ZIP code
20. County of residence	21. Language spoken	22. Name of parent/legal guardian
23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number ( )

Insurance Information

26.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number
27. Enrolled in commercial insurance plan ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

28.
Diagnosis (DX)/ICD-10:_____ DX/ICD-10:_____ DX/ICD-10:_____

Requested Services

29.* CPT-4/ HCPCS Code/NDC	30. Specific Description of Service/Procedure	31. From (mm/dd/yy)	To (mm/dd/yy)	32. Frequency/ Duration	33. Units	34. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

35. Other documentation attached ☐ Yes	36. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

37. Begin date	38. End date	39. Number of days

Additional Services Requested from Other Health Care Provider

40. **Provider's name**	Provider number	Telephone number ( )	Contact person
Address (number, street)	City	State	ZIP code
Description of services	Procedure code	Units	Quantity
Additional information			

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

41. Signature of physician/provider or authorized designee	42. Date

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Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter National Provider Identification (NPI) number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
13. Medical record number: Enter the client's hospital or office medical record number.
14. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the address of the client. Do not use a P.O. Box number.
19. Mailing address: Enter the mailing address if it is different than number 18.
20. County of residence: Enter residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

26a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.

27. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

28. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

29. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
30. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
31. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
32. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
33. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
34. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
35. Other documentation attached: Check this box if attaching additional documentation.
36. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

37. Begin date: Enter the date the requested inpatient stay shall begin.
38. End date: Enter the end date for the inpatient stay requested.
39. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

40. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's National Provider Identification (NPI) number. Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request. Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

41. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
42. Date: Enter the date the request is signed.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

15. Approve Modifications to CalOptima Grievance and Appeals Resolution Services Policies: GG.1510, HH.1102, HH.1103, HH.1109, HH.1104, MA.9001, MA.9002, MA.9003, MA.9004, MA.9005 and MA.9009

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions

1. Approve modifications to Grievance and Appeals Resolution Services (GARS) Department policies and procedures:
   i. Policy GG.1510: Appeal Process
   ii. Policy HH.1102: Member Grievance
   iii. Policy HH.1103: Health Network Grievance & Appeal Process
   iv. Policy HH.1109: Complaints Decision Matrix

2. Approve modifications and ratify staff's implementation of said changes to the following GARS Department policies and procedures effective as of April 1, 2022, due to time sensitivity of updates for regulatory compliance:
   i. Policy HH.1104: Complaints of Discrimination
   ii. Policy MA.9002: Member Grievance Process
   iii. Policy MA.9003: Standard Pre-Service Appeal
   iv. Policy MA.9004: Expedited Pre-Service Appeal
   v. Policy MA.9005: Payment Appeal
   vi. Policy MA.9009: Non-Contracted Provider Payment Disputes

3. Approve retirement of policy and procedure MA.9001: Complaint Process, and ratify the effective retirement date of April 1, 2022.

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 are descriptions of the impacted policies, followed by the rationale for changes, which are reflected in the attached redlines. The list does not include non-substantive changes that may also be reflected in the redlines (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

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Modified Policies for Approval:

Policy GG.1510: Appeal Process describes the process by which CalOptima addresses and resolves Utilization Management (UM) appeals, including adverse benefit determinations involving the delay, modification, or denial of services based on medical necessity or determinations that requested services are not a covered benefit. This policy was updated to align with the requirements of Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and Your Rights Templates released in August 2021, as well as DHCS APL 20-017 Requirements for Reporting Managed Care Program Data released in October 2020.

Policy HH.1102: Member Grievance describes the process by which CalOptima addresses and resolves grievances from a member, or a provider or authorized representative, acting on behalf of a member and with the member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements. This policy was updated to align with the requirements of DHCS APL 21-011 Grievance and Appeal Requirements, Notice and Your Rights Templates.

Policy HH.1103 Health Network Member Grievance & Appeal Process defines the process by which a Health Network shall address and resolve grievances and appeals for members enrolled in the Health Network as delegated by CalOptima, under supervision of CalOptima's GARS Department. This policy was updated to comply with Medi-Cal Contract Amendments and DHCS APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, which was released in April 2021 and revised in January 2022.

Policy HH.1109 Complaint Decision Matrix defines the process and structure for identifying and referring all member and provider complaints that require administrative approval for resolution by CalOptima. This policy was updated to include complaints regarding discrimination to comply with DHCS APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services.

Policies for Approval and Ratification of Effective Date of April 1, 2022:

Policy HH.1104 Complaints of Discrimination defines the criteria by which CalOptima responds to, tracks, and reports complaints related to allegations of discrimination. This policy was revised to align with DHCS APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services.

Policy MA.9002 Member Grievance Process defines the process by which CalOptima shall address and resolve a member's grievance in accordance with applicable statutory provisions, and regulatory and contractual Centers for Medicare and Medicaid Services (CMS) requirements. This policy was revised to align with the CMS changes to Parts C and D Enrollee Grievance, Organization/Coverage Determinations and Appeals Guidance released in December 2019.

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Policy MA.9003 Standard Pre-Service Appeal addresses Medicare Part C standard appeals and describes the process by which CalOptima ensures that members have clear and reliable access to the standard appeal process for pre-service organization determinations consistent with CMS requirements. This policy was revised to align with the CMS Parts C and D Enrollee Grievance, Organization/Coverage Determinations and Appeals Guidance.

Policy MA.9004 Expedited Pre-Service Appeal addresses Medicare Part C expedited appeals and describes the process by which CalOptima ensures that members have clear and reliable access to an expedited appeal process for pre-service organization determinations consistent with CMS requirements. This policy was revised to align with the CMS Parts C and D Enrollee Grievance, Organization/Coverage Determinations and Appeals Guidance.

Policy MA.9005 Payment Appeal defines the process by which CalOptima shall ensure that members have clear and reliable access to a payment appeal process that meets CMS requirements. This policy was revised to align with the CMS Parts C and D Enrollee Grievance Organization/Coverage Determinations and Appeals Guidance.

Policy MA.9009 Non-Contracted Provider Payment Appeals defines the process by which CalOptima ensures that non-contracted providers (NCP) have clear and reliable access to an appeal process (separate from the member appeal process) that meets CMS requirements. This policy was revised to align with the CMS Parts C and D Enrollee Grievance Organization/Coverage Determinations and Appeals Guidance.

Retired Policy for Approval and Ratification of Retirement date of April 1, 2022:

Policy MA.9001 Complaints Process describes the process by which CalOptima addresses and resolves a complaint in accordance with applicable statutory, regulatory, and contractual requirements. This policy is being retired due to CMS's retirement of the term "Complaint" for handling and describing grievance and appeals procedures. All processes for grievances and appeals are covered under specific relevant policies.

Fiscal Impact

The recommended action to approve revisions to CalOptima Policies GG.1510, HH.1102, HH.1103, HH.1109, ratify revisions to HH.1104, MA.9002, MA.9003, MA.9004, MA.9005, MA.9009, and ratify retirement of MA.9001 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 procedure will supersede prior versions.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy GG.1510: Appeal Process (Red Lined and Clean)
2. Policy HH.1102: Member Grievance (Red Lined and Clean)
3. Policy HH.1103: Health Network Grievance & Appeal Process (Red Lined and Clean)
4. Policy HH.1109: Complaints Decision Matrix (Red Lined and Clean)
5. Policy HH.1104: Complaints of Discrimination (Red Lined and Clean)
6. Policy MA.9001: Complaint Process – For retirement
7. Policy MA.9002: Member Grievance Process (Red Lined and Clean)
8. Policy MA.9003: Standard Pre-Service Appeal (Red Lined and Clean)
9. Policy MA.9004: Expedited Pre-Service Appeal (Red Lined and Clean)
10. Policy MA.9005: Payment Appeal (Red Lined and Clean)
11. Policy MA.9009: Non-Contracted Provider Payment Appeals (Redlined and Clean)

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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Policy:	GG.1510
Title:	**Member Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This ~~policy~~Policy defines the process by which CalOptima addresses and resolves Utilization Management (UM) Appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima shall establish and maintain an Appeal Process pursuant to applicable statutory, regulatory, and contractual requirements.

B. A Member, or a ~~Member's~~Provider or Authorized Representative~~, or Provider~~ acting on behalf of the Member, and with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this ~~policy~~Policy.

C. CalOptima's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

D. CalOptima shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs and in accordance with Section III.G.1. of this Policy.

E. CalOptima shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

F. CalOptima shall refer all Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

G. CalOptima or a Health Network shall advise and assist the Member with the provision of Aid Paid Pending, regardless of whether the Member makes a separate request to CalOptima during the Appeal process, if all of the following conditions are met:

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1. The Member filed their Appeal within the required timeframes for Aid Paid Pending (within 10 calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action, whichever is later);

2. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3. The Covered Services were ordered by an authorized Provider; and

4. The period covered by the original authorization has not expired.

H. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

~~G.~~I. CalOptima and a Health Network shall inform a Member~~,~~ during the Appeal Process~~,~~ of ~~their~~his or her right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of ~~their~~his or her right to Aid Paid Pending~~,~~ (i.e., continuation of benefits), in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

~~H.~~J. Neither CalOptima, nor any of its Health Networks, Practitioners, or other Providers shall discriminate against a Member, ~~a~~or a Provider or Member's Authorized Representative~~, or a Provider~~ on the grounds that he or she filed an Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

~~I.~~K. A Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) sent by CalOptima or a Health Network notifying a Provider or a Member of a CalOptima or Health Network UM decision to delay, deny, modify, or recommend an alternative option to a requested service, shall inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.

~~J.~~L. The Member UM Appeal ~~process~~Process set forth in this ~~policy~~Policy is a separate process from the Member Grievance Process in CalOptima Policy HH.1102: Member Grievance and Member State Hearing Process in CalOptima Policy HH.1108: State Hearing Process and Procedures. It is also separate from Provider processes in CalOptima Policy HH.1101: CalOptima Provider Complaint.

~~K.~~M. CalOptima shall give a Member, or a ~~Member's~~Provider or Authorized Representative~~, or Provider,~~ acting on behalf of the Member and with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. ~~-~~CalOptima and a Health Network shall inform the Member, ~~the Member's~~or a Provider or Authorized Representative, ~~or Provider,~~ acting on behalf of the Member and with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Appeals.

~~L.~~N. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals ~~Process~~process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services~~.~~, including but not be limited to, Acknowledgement Letters and Notices of Appeal Resolution.

~~M.~~O. A Member may be represented by anyone they choose during the Appeal Process, including a legal representative.

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~~N.~~P. The Member has the right to request an Appeal in the event ~~that~~ CalOptima or a Health Network fails to issue a NABD/NOA within the required time frame, which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

~~O.~~Q. CalOptima shall provide, upon request by the Member, ~~his~~ or ~~her~~ a Provider or Authorized Representative~~, or Provider,~~ acting on behalf of the Member and with the Member's written consent, before and during the Appeals Process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals Process. CalOptima shall provide records at no cost.

~~P.~~R. CalOptima shall ensure that the person reviewing the UM Appeal was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.

~~Q.~~S. CalOptima shall ensure that for UM Appeals, the person making the final decision for the proposed resolution of an Appeal has not participated in any prior decisions related to the Appeal and is of the same or similar specialty ~~and,~~ has clinical expertise in treating the Member's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity or experimental/clinical investigation; and

2. Any Appeal involving clinical issues.

~~R.~~T. A Member shall continue to receive ~~the continuation of the benefit~~Aid Paid Pending while an Appeal is pending until one (1) of the following occurs:

1. Member withdraws the Appeal;

~~2. Ten (10) days pass after CalOptima mails the NABD/NOA;~~

~~3.~~2. Grievance and Appeals Resolution Services (GARS) issues an Appeal decision adverse to the Member; ~~and~~or

~~4.~~3. The time period or service limits of a previously authorized service has been met.

T. A Provider, with the Member's written consent, may request a UM Appeal on behalf of the Member, for services rendered to that CalOptima Member, by submitting a written request to CalOptima within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network, in accordance with the provisions of this ~~policy~~Policy.

U. A Provider may request a UM Appeal on his or her own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

~~U.~~V. Upon notice of a CalOptima decision to deny an authorization request, a Member, or a ~~Member's~~Provider or Authorized Representative~~, or a Provider,~~ acting on behalf of the Member, and with the Member's written consent, may request an expedited UM Appeal in accordance with Section III.D. of this Policy, when it is determined or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

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~~V.~~W. All medical Appeals are referred to the Chief Medical Officer (CMO~~),~~) or to his or her Designee~~,~~ who has the authority to require corrective action~~,~~ and did not make the initial utilization management decision.

~~W.~~X. CalOptima and a Health Network shall provide the CalOptima Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract~~.~~, on an annual basis, and when CalOptima's or the Health Network's relevant grievance and appeals policies and procedures are updated.

~~X.~~Y. CalOptima shall provide language assistance to Members, by CalOptima staff or language line interpreter services, for Threshold Languages to register and resolve Appeals.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make ~~complaint~~grievance and appeal forms and procedures for filing an Appeal available to facilities that provide Covered Services to Members.

2. CalOptima shall provide the ~~complaint~~grievance and appeal forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing an Appeal~~,~~ and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Appeal Process

1. A CalOptima Member, or a Provider or Authorized Representative acting on behalf of a Member, and with the Member's written consent, may request a UM Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network orally or in writing by the following methods:

   a. Make a request to CalOptima's Customer Service Department, by telephone, or in person; or

   b. Make a request to CalOptima's Grievance and Appeals Resolution Services (GARS), by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

2. UM Appeal requests serve as documentation of the substance of the Appeal and any action taken, and all requests must:

   a. Include all relevant material, such as clinical documentation or other documentation supporting the request; and

   b. Be clearly labeled as a "UM Appeal."

~~1.~~3. GARS shall:

   a. Date stamp and document the substance of the Appeal, and any action taken, in the GARS database, verifying demographics and network affiliation.

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b. Determine the category of Appeal (coverage dispute, Medical Necessity, non-coverage appeal, and other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

c. ~~Send~~Except as otherwise provided in Section III.D. of this Policy, send a Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, an Acknowledgment Letter within five (5) calendar days after receipt of an Appeal, ~~indicating receipt of~~that includes the following information:

i. An acknowledgement the Appeal ~~and identifying a~~ was received;

ii. The name, telephone number, and address of the GARS staff member ~~whom the Member~~ who may ~~contact~~be contacted regarding the Appeal~~, and provide the Member with an~~;

~~i.~~iii. An estimated completion date of resolution~~.~~;

iv. Notice that the appealing party may submit additional information (written or in person) and/or request to review or obtain a copy of the records in connection with the Appeal.

d. Send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member, excluding expedited Appeals.

i. The date of the oral Appeal establishes the filing date for the Appeal.

e. Process the Appeal regardless of whether ~~or not~~ a signed written Appeal ~~confirmation~~request is received subsequently from the Member.

f. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Appeal.

g. Ensure an appeals nurse specialist in CalOptima's GARS Department investigates the Appeal, including any aspects of clinical care involved, by:

i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; and

iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

h. Utilize specialist consultants, as appropriate.

~~g.~~i. Review and immediately process all Appeals of an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the resolution of an expedited review as required in the CalOptima contract with Department of Health Care Services (DHCS~~).~~), in accordance with procedures outlined in Section III.D. of this Policy.

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~~h.~~j. Escalate the Appeal for review of the factual findings, proposed ~~Resolution~~resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Appeal.

~~i.~~k. Send the Member and/or Provider or Member's Authorized Representative, acting on behalf of the Member and with the Member's written consent, if applicable, a Notice of Appeal Resolution letter within thirty (30) calendar days after receipt of the Appeal~~.~~, except as otherwise provided in Section III.D. of this Policy.

i. The Notice of Appeal Resolution letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a) The results of the resolution and the date it was completed;

b) If CalOptima upholds a denial determination that is based in whole or in part on Medical Necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

c) If CalOptima upholds a denial based on a determination that the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service:

i. Identify the document and page or section containing the provision, or provide a copy of the provision;

ii. If the requested service is a code listed as a non-benefit in the Medi-Cal Treatment Authorization (TAR) and Non-Benefit list of codes, then this shall not be the sole reason for denial and any other reason(s) must also be included in the explanation (for example, the services were determined to be not medically necessary and/or did not meet other criteria considered).

d) If CalOptima overturns the denial determination, a clear and concise explanation of why the decision was overturned;

e) Any referrals to the Quality Improvement (QI) Department for quality of care review;

f) Alternative resources or references, when applicable;

g) The State Hearing process and Member's right to request and receive Aid Paid Pending while the State Hearing is pending and instructions on how to request Aid Paid Pending, including the timeframe in which the request shall be made; and

h) For Appeals in which CalOptima holds a denial determination, the "Your Rights" template.

~~j.~~l. Translate Notice of Appeal Resolution letters into Threshold Languages, and offer oral interpretation for a Notice of Appeal Resolution letter for all other languages, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

n. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter in the electronic file and document any oral notification provided to the Member.

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i. The Notice of Appeal Resolution letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a) The results of the resolution and the date it was completed;

a. If the denial determination is based in whole or in part on Medical Necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

b. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

b)a)Any referrals to the Quality Improvement (QI) Department for quality of care review;

Alternative resources or references, when applicable; and

c. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

C. UM Pre-service Appeal

D.C.

1. Request for UM Appeal

a. A CalOptima Member, or his or her Authorized Representative, or a Provider with Member's written consent, may request a UM Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network by the following methods:

i. To CalOptima's Customer Service Department, by telephone, or in person; or

ii. To CalOptima's Grievance and Appeals Resolution Services (GARS), by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

b. A Provider may request a UM Appeal on his or her own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member.

c. This request serves as the documentation of the substance of the Appeal and any action taken;

c.a. i. Include all relevant material, such as clinical documentation or other documentation supporting the request; and

ii. Clearly label the request with "UM Appeal."

2. Acknowledgement of UM Appeal

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a. Except as otherwise provided in Section III.D of this policy, CalOptima's Grievance and Appeals Resolution Services shall send the CalOptima Member, or Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, an Acknowledgment Letter that is dated and postmarked within five (5) calendar days after receipt of a UM Appeal.

b. The letter shall indicate the receipt of the UM Appeal, and identify a Grievance and Appeals Resolution Services staff member whom the Member, Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, may contact if they choose to submit additional information (written or in person) and/or the request to review or obtain a copy of the records in connection with the UM Appeal.

3.1. UM Pre-service Appeal Processing

a. Upon receipt of a UM Appeal from a CalOptima Member, or hisa Provider or her Authorized Representative or Provider, acting on behalf of the Member, and with the Member's written consent, an appeals nurse specialist in CalOptima's Grievance and Appeals Resolution Services shall investigate the Appeal, including any aspects of clinical care involved, by:

i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

i. ii. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

i.ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; orand

ii.iii. iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

b. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action and did not make the initial utilization management decision.

c. CalOptima shall utilize specialist consultants, as appropriate.

4.2. UM Pre-service Appeals Resolution

a. Except as otherwise provided in Section III.D. of this policyPolicy, CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

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b. ~~i.~~ If CalOptima completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

c. ~~ii.~~ If CalOptima does not completely overturn the denial, such written notice shall include information ~~regarding~~including: the title, qualification~~,~~ and specialty of the person making the decision, how the Member or Provider may obtain~~, upon request,~~ copies of the Appeal file documentation or criteria used to make the Appeal decision~~:~~,, the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures, and the Member's right to have a representative act on their behalf ~~when he or she appeals~~for an Appeal.

d. ~~iii.~~ If CalOptima upholds a UM decision involving the delay, denial, or modification of health care services, the Notice of Appeal Resolution shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

e. ~~iv.~~ If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested~~.~~, or at a minimum, must include:

i. The Member's rights to request a State Fair Hearing;

ii. How to request a State Fair Hearing;

iii. The right to continue to receive Covered Services pending a State Fair Hearing;

iv. How to request Aid Paid Pending and requirements to file a continuation within ten (10) calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action; and

v. The DHCS-approved "Your Rights" attachment.

f. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

~~b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.~~

~~E.~~D. Member UM Expedited Appeal

1. If CalOptima determines, for a request from a Member, or when the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, or a Provider or Member's

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Authorized Representative~~, or a Provider~~ acting on behalf of the Member and with the Member's written consent, may request an expedited UM Appeal to CalOptima as follows:

a. A CalOptima Member, or a Provider or Member's Authorized Representative~~, or Provider~~ acting on behalf of the CalOptima Member~~;~~ and with the Member's written consent, may request an expedited UM Appeal by contacting CalOptima's Customer Service Department by telephone or in-person, or contacting CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Website at ~~www.caloptima.org~~www.caloptima.org. No additional follow-up from the Member is required.

b. CalOptima staff shall inform the Member of limited time to present evidence in person or writing to support the UM Appeal.

2. Upon receipt of a Member request for an expedited UM Appeal, CalOptima's CMO or ~~his or her~~ Designee shall review the request to determine if the expedited review criteria is met and shall conduct a medical review, as deemed necessary, based on whether a delay:

a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

b. In the opinion of a Provider with knowledge of the Member's ~~Medical Condition~~medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. CalOptima shall grant expedited Appeal requests concerning admission, continued stay or other health care services for a Member who has received emergency services but, has not been discharged from a facility.

4. Expedited Appeals filed by a physician shall be processed as expedited without further review.

5. CalOptima shall utilize specialist consultants, as appropriate.

6. CalOptima shall make a decision on the expedited UM Appeal as quickly as the medical decision requires but no later than seventy-two (72) hours after CalOptima receives the expedited UM Appeal request.

7. CalOptima shall notify a Member, ~~the Member's~~ or a Provider or Authorized Representative~~, or Provider that made the request~~ acting on behalf of the ~~CalOptima~~ Member and with the Member's written consent, within twenty-four (24) hours, by telephone, and written notice within two (2) calendar days of the ~~verbal~~oral notice, if the Appeal does not meet expedited UM Appeal criteria.

8. CalOptima shall notify the Member, ~~the Member's~~ or a Provider or Authorized Representative~~, and all involved Providers~~ acting on behalf of the CalOptima Member with the Member's written consent, of the expedited UM Appeal decision ~~by facsimile or verbal communication~~through oral notice or in writing within seventy-two (72) hours after receiving the expedited UM Appeal request. CalOptima shall provide a written notice within one (1) business day after ~~a verbal~~an oral notice.

~~F.~~E. UM Post-service Appeal ~~processing~~Processing

1. CalOptima Grievance and Appeals Resolution Services staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the

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Member, provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative~~,~~ or Provider.

2. A Grievance and Appeals Resolution Services Appeals nurse shall investigate, review and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or his or her Designee for review.

3. All medical Appeals are referred to the CMO~~,~~ or ~~to~~ his or her Designee~~,~~ who has the authority to require corrective action, is of the same or similar specialty, is able to treat complications that may result from the service or procedure, and did not make the initial utilization management decision.

4. CalOptima shall utilize specialist consultants as appropriate.

5. ~~5.~~ UM Post-service Appeals ~~resolution~~Resolution

   a. CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal

   ~~a.~~b. If CalOptima completely overturns the decision, the ~~letter~~Notice of Appeal Resolution shall state the decision and the date of the decision. ~~-~~CalOptima shall also ensure the written response sent to the appealing party contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

   ~~f. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.~~

   ~~b.~~c. If CalOptima does not completely overturn the decision, such written notice shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits pending a State Hearing, and the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when he or she appeals.

   ~~a. CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.~~

   ~~c.~~d. If CalOptima upholds a UM Appeal decision ~~involving the denial of health care services~~, in whole or in part, the Notice of Appeal Resolution shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member~~.~~,

   ~~b. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall clearly specify the provisions of the contract that exclude that service and or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.~~ or at a minimum, must include:

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i. The Member's right to request a State Fair Hearing;

ii. How to request a State Fair Hearing;

iii. The right to continue to receive benefits pending a State Fair Hearing (Aid Paid Pending);

iv. How to request the continuation of benefits (Aid Paid Pending) and requirements to file a continuation within ten (10) calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action; and

v. The DHCS-approved "Your Rights" attachment.

e. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

~~G.~~F. External Appeals

1. CalOptima shall annually inform Members of the right to a State Hearing through the Medi-Cal Member Newsletter, including that the information is also available on the CalOptima Website at www.caloptima.org. CalOptima must also advise Members of their right to file an expedited State Hearing.

2. CalOptima shall include written or electronic notifications to Members in the resolution letter detailing the State Hearing rights, time limitations and processes, including the contact information for the California Department of Social Services.

3. In the event CalOptima fails to meet or respond to the thirty (30) calendar day resolution timeline or comply with the notice requirements of Title 42 C.F.R. section 438.10, the Member is deemed to have exhausted CalOptima's internal Appeal ~~process~~Process and may initiate a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

4. A Member eligible with California Children's Services (CCS) and transitioned into the Whole-Child Model (WCM) Program, the Member's family or designated caregiver may appeal a Continuity of Care limitation, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and this ~~policy~~Policy.

G. In addition to any rights set forth in this ~~policy~~Policy, a Member shall also have the right to:

1. ~~Request that CalOptima provide an interpreter, or auxiliary aide~~Request that CalOptima provide assistance to Members when completing Appeal forms and other procedural steps, including but not limited to, providing all documents relied on for CalOptima's decision to the Member, and providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services, for assistance in the Appeal Process, or to provide translation of Appeal correspondence; and

2. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

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3. CalOptima shall inform a Member of these rights annually, and in every Notice of Appeal Resolution letter.

H. Responsible staff-

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Appeal Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Appeal Process.

I. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations ~~for filing a Grievance,~~ and telephone numbers where an Appeal ~~may~~should be submitted, and related procedures regarding ~~the Appeal Process~~these processes. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Appeal, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall continually evaluate and analyze Appeal data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.

~~3.~~4. CalOptima shall submit a monthly report of complete, accurate, reasonable, and timely aggregated Appeal data~~,~~ within ten (10) calendar days following the end of each month or as ~~required~~otherwise agreed upon by DHCS, and in the format specified with DHCS, in accordance with this Policy and CalOptima Policy AA.1270: Certification of Document and Data Submissions.

~~4.~~5. CalOptima shall submit, on a quarterly basis, aggregate and detailed Appeals data to the Quality Assurance Committee.

~~5.~~6. CalOptima shall submit a report of Appeals related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Appeals or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Appeal was reported to the County of Orange or MSSP site.

~~6.~~7. CalOptima shall establish and maintain a system of aging of Appeals that are pending and unresolved for thirty (30) calendar days or more.

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IV. ATTACHMENT(S)

~~A. Acknowledgment Letter~~
~~B. Notice of Appeal Resolution (Uphold)~~
~~C. Notice of Appeal Resolution (Overturn)~~
Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1270: Certification of Document and Data Submissions
~~B.~~C. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~C.~~D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
~~D.~~E. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~E.~~F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Policy GG.1611: Potential Quality Issue Review Process
~~F.~~H. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~G.~~I. CalOptima Policy HH.1102: Member Grievance
J. CalOptima Policy HH.1104: Complaints of Discrimination
~~H.~~K. CalOptima Policy HH.1108: State Hearing Process and Procedures
~~I.~~L. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
~~J.~~M. CalOptima Member Handbook
~~K.~~N. Department of Health Care Services All Plan Letter ~~17-006: Grievance and Appeal Requirements and~~ (APL) 20-017: Requirements for Reporting Managed Care Program Data~~Revised Notice Templates and "Your Rights" Attachments~~
~~L.~~O. Department of Health Care Services All Plan Letter (APL) 20-020: Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
P. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Template
~~M.~~Q. Title 22, California Code of Regulations~~, §~~ (C.C.R.), §§ 51014.2, and 53858
~~A.~~ Title 28, California Code of Regulations~~,~~ (C.C.R.), § 1300.68 (except Subdivision 1300.68(c)(g) and (h~~)~~)
~~N.~~R. ~~Title 28, California Code of Regulations, §)~~), and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
~~O.~~S. Title 42, Code of Federal Regulations~~, §§~~ (C.F.R.), § 438.10, 438.402~~(c)(2)(ii), 438.402(c)(3)(ii), 438.406(b)(3), 438.408(d)(2)(ii), 438.410, 438.420(a)(b)(c)~~ 424

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/22/2015	Department of Health Care Services (DHCS)	Approved as Submitted
02/03/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

For 2/2/2023 BOD Review Only

TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/1995	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/1998	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	05/1999	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	08/01/2004	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2007	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	06/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2011	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2012	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	09/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	11/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	04/01/2016	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/07/2019	GG.1510	Appeal Process	Medi-Cal
Revised	05/01/2021	GG.1510	Appeal Process	Medi-Cal
Revised	TBD	GG.1510	Member Appeal Process	Medi-Cal

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IX. GLOSSARY

Term	Definitions
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.
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). ~~6.~~5.
Adverse Benefit Determination	~~Denial,~~Any of the following actions taken by CalOptima: 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 ~~requested~~previously authorized service~~, including~~. 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 ~~a decision~~services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. For a resident of a rural area with only one MCP, the denial of the Member’s request to obtain services outside the network. ~~1.~~7. The denial of a Member’s request to dispute financial liability.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member’s parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
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.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.

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Term	Definitions
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 ~~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 not-withstanding 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.
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.
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.

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Term	Definitions
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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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.
State Hearing	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.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Utilization Management (UM) Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.

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Policy:	GG.1510
Title:	**Member Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy defines the process by which CalOptima addresses and resolves Utilization Management (UM) Appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima shall establish and maintain an Appeal Process pursuant to applicable statutory, regulatory, and contractual requirements.

B. A Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this Policy.

C. CalOptima's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

D. CalOptima shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs and in accordance with Section III.G.1. of this Policy.

E. CalOptima shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

F. CalOptima shall refer all Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

G. CalOptima or a Health Network shall advise and assist the Member with the provision of Aid Paid Pending, regardless of whether the Member makes a separate request to CalOptima during the Appeal process, if all of the following conditions are met:

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1. The Member filed their Appeal within the required timeframes for Aid Paid Pending (within 10 calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action, whichever is later);

2. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3. The Covered Services were ordered by an authorized Provider; and

4. The period covered by the original authorization has not expired.

H. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

I. CalOptima and a Health Network shall inform a Member during the Appeal Process of his or her right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of his or her right to Aid Paid Pending (i.e., continuation of benefits), in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

J. Neither CalOptima, nor any of its Health Networks, Practitioners, or other Providers shall discriminate against a Member, or a Provider or Member's Authorized Representative on the grounds that he or she filed an Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

K. A Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) sent by CalOptima or a Health Network notifying a Provider or a Member of a CalOptima or Health Network UM decision to delay, deny, modify, or recommend an alternative option to a requested service, shall inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.

L. The Member UM Appeal Process set forth in this Policy is a separate process from the Member Grievance Process in CalOptima Policy HH.1102: Member Grievance and Member State Hearing Process in CalOptima Policy HH.1108: State Hearing Process and Procedures. It is also separate from Provider processes in CalOptima Policy HH.1101: CalOptima Provider Complaint.

M. CalOptima shall give a Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. CalOptima and a Health Network shall inform the Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Appeals.

N. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services, including but not be limited to, Acknowledgement Letters and Notices of Appeal Resolution.

O. A Member may be represented by anyone they choose during the Appeal Process, including a legal representative.

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P. The Member has the right to request an Appeal in the event CalOptima or a Health Network fails to issue a NABD/NOA within the required time frame, which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

Q. CalOptima shall provide, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, before and during the Appeals Process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals Process. CalOptima shall provide records at no cost.

R. CalOptima shall ensure that the person reviewing the UM Appeal was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.

S. CalOptima shall ensure that for UM Appeals, the person making the final decision for the proposed resolution of an Appeal has not participated in any prior decisions related to the Appeal and is of the same or similar specialty, has clinical expertise in treating the Member's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity or experimental/clinical investigation; and

2. Any Appeal involving clinical issues.

T. A Member shall continue to receive Aid Paid Pending while an Appeal is pending until one (1) of the following occurs:

1. Member withdraws the Appeal;

2. Grievance and Appeals Resolution Services (GARS) issues an Appeal decision adverse to the Member; or

3. The time period or service limits of a previously authorized service has been met.

T. A Provider, with the Member's written consent, may request a UM Appeal on behalf of the Member, for services rendered to that CalOptima Member, by submitting a written request to CalOptima within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network, in accordance with the provisions of this Policy.

U. A Provider may request a UM Appeal on his or her own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

V. Upon notice of a CalOptima decision to deny an authorization request, a Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent, may request an expedited UM Appeal in accordance with Section III.D. of this Policy, when it is determined or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

W. All medical Appeals are referred to the Chief Medical Officer (CMO) or to his or her Designee who has the authority to require corrective action and did not make the initial utilization management decision.

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X. CalOptima and a Health Network shall provide the CalOptima Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract, on an annual basis, and when CalOptima's or the Health Network's relevant grievance and appeals policies and procedures are updated.

Y. CalOptima shall provide language assistance to Members, by CalOptima staff or language line interpreter services, for Threshold Languages to register and resolve Appeals.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make grievance and appeal forms and procedures for filing an Appeal available to facilities that provide Covered Services to Members.

2. CalOptima shall provide the grievance and appeal forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing an Appeal and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Appeal Process

1. A CalOptima Member, or a Provider or Authorized Representative acting on behalf of a Member, and with the Member's written consent, may request a UM Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network orally or in writing by the following methods:

   a. Make a request to CalOptima's Customer Service Department, by telephone, or in person; or

   b. Make a request to CalOptima's Grievance and Appeals Resolution Services (GARS), by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

2. UM Appeal requests serve as documentation of the substance of the Appeal and any action taken, and all requests must:

   a. Include all relevant material, such as clinical documentation or other documentation supporting the request; and

   b. Be clearly labeled as a "UM Appeal."

3. GARS shall:

   a. Date stamp and document the substance of the Appeal, and any action taken, in the GARS database, verifying demographics and network affiliation.

   b. Determine the category of Appeal (coverage dispute, Medical Necessity, non-coverage appeal, and other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

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c. Except as otherwise provided in Section III.D. of this Policy, send a Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, an Acknowledgment Letter within five (5) calendar days after receipt of an Appeal, that includes the following information:

   i. An acknowledgement the Appeal was received;

   ii. The name, telephone number, and address of the GARS staff member who may be contacted regarding the Appeal;

   iii. An estimated completion date of resolution;

   iv. Notice that the appealing party may submit additional information (written or in person) and/or request to review or obtain a copy of the records in connection with the Appeal.

d. Send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member, excluding expedited Appeals.

   i. The date of the oral Appeal establishes the filing date for the Appeal.

e. Process the Appeal regardless of whether a signed written Appeal request is received subsequently from the Member.

f. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Appeal.

g. Ensure an appeals nurse specialist in CalOptima's GARS Department investigates the Appeal, including any aspects of clinical care involved, by:

   i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

   ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; and

   iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

h. Utilize specialist consultants, as appropriate.

i. Review and immediately process all Appeals of an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the resolution of an expedited review as required in the CalOptima contract with Department of Health Care Services (DHCS), in accordance with procedures outlined in Section III.D. of this Policy.

j. Escalate the Appeal for review of the factual findings, proposed resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Appeal.

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k. Send the Member and/or Provider or Member's Authorized Representative, acting on behalf of the Member and with the Member's written consent, if applicable, a Notice of Appeal Resolution letter within thirty (30) calendar days after receipt of the Appeal, except as otherwise provided in Section III.D. of this Policy.

i. The Notice of Appeal Resolution letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a) The results of the resolution and the date it was completed;

b) If CalOptima upholds a denial determination that is based in whole or in part on Medical Necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

c) If CalOptima upholds a denial based on a determination that the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service:

i. Identify the document and page or section containing the provision, or provide a copy of the provision;

ii. If the requested service is a code listed as a non-benefit in the Medi-Cal Treatment Authorization (TAR) and Non-Benefit list of codes, then this shall not be the sole reason for denial and any other reason(s) must also be included in the explanation (for example, the services were determined to be not medically necessary and/or did not meet other criteria considered).

d) If CalOptima overturns the denial determination, a clear and concise explanation of why the decision was overturned;

e) Any referrals to the Quality Improvement (QI) Department for quality of care review;

f) Alternative resources or references, when applicable;

g) The State Hearing process and Member's right to request and receive Aid Paid Pending while the State Hearing is pending and instructions on how to request Aid Paid Pending, including the timeframe in which the request shall be made; and

h) For Appeals in which CalOptima holds a denial determination, the "Your Rights" template.

l. Translate Notice of Appeal Resolution letters into Threshold Languages, and offer oral interpretation for a Notice of Appeal Resolution letter for all other languages, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

n. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter in the electronic file and document any oral notification provided to the Member.

C. UM Pre-service Appeal

1. UM Pre-service Appeal Processing

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a. Upon receipt of a UM Appeal from a CalOptima Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent, an appeals nurse specialist in CalOptima's Grievance and Appeals Resolution Services shall investigate the Appeal, including any aspects of clinical care involved, by:

   i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

   ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; and

   iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

b. All medical Appeals are referred to the CMO or to his or her Designee who has the authority to require corrective action and did not make the initial utilization management decision.

c. CalOptima shall utilize specialist consultants, as appropriate.

2. UM Pre-service Appeals Resolution

a. Except as otherwise provided in Section III.D. of this Policy, CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

b. If CalOptima completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

c. If CalOptima does not completely overturn the denial, such written notice shall include information including: the title, qualification and specialty of the person making the decision, how the Member or Provider may obtain copies of the Appeal file documentation or criteria used to make the Appeal decision, the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures, and the Member's right to have a representative act on their behalf for an Appeal.

d. If CalOptima upholds a UM decision involving the delay, denial, or modification of health care services, the Notice of Appeal Resolution shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

e. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested, or at a minimum, must include:

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i. The Member's rights to request a State Fair Hearing;

ii. How to request a State Fair Hearing;

iii. The right to continue to receive Covered Services pending a State Fair Hearing;

iv. How to request Aid Paid Pending and requirements to file a continuation within ten (10) calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action; and

v. The DHCS-approved "Your Rights" attachment.

f. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

D. Member UM Expedited Appeal

1. If CalOptima determines, for a request from a Member, or when the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, or a Provider or Member's Authorized Representative acting on behalf of the Member and with the Member's written consent, may request an expedited UM Appeal to CalOptima as follows:

   a. A CalOptima Member, or a Provider or Member's Authorized Representative acting on behalf of the CalOptima Member and with the Member's written consent, may request an expedited UM Appeal by contacting CalOptima's Customer Service Department by telephone or in-person, or contacting CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Website at www.caloptima.org. No additional follow-up from the Member is required.

   b. CalOptima staff shall inform the Member of limited time to present evidence in person or writing to support the UM Appeal.

2. Upon receipt of a Member request for an expedited UM Appeal, CalOptima's CMO or Designee shall review the request to determine if the expedited review criteria is met and shall conduct a medical review, as deemed necessary, based on whether a delay:

   a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

   b. In the opinion of a Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. CalOptima shall grant expedited Appeal requests concerning admission, continued stay or other health care services for a Member who has received emergency services but, has not been discharged from a facility.

4. Expedited Appeals filed by a physician shall be processed as expedited without further review.

5. CalOptima shall utilize specialist consultants, as appropriate.

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6. CalOptima shall make a decision on the expedited UM Appeal as quickly as the medical decision requires but no later than seventy-two (72) hours after CalOptima receives the expedited UM Appeal request.

7. CalOptima shall notify a Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, within twenty-four (24) hours, by telephone, and written notice within two (2) calendar days of the oral notice, if the Appeal does not meet expedited UM Appeal criteria.

8. CalOptima shall notify the Member, or a Provider or Authorized Representative acting on behalf of the CalOptima Member with the Member's written consent, of the expedited UM Appeal decision through oral notice or in writing within seventy-two (72) hours after receiving the expedited UM Appeal request. CalOptima shall provide a written notice within one (1) business day after an oral notice.

E. UM Post-service Appeal Processing

1. CalOptima Grievance and Appeals Resolution Services staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative or Provider.

2. A Grievance and Appeals Resolution Services Appeals nurse shall investigate, review and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or his or her Designee for review.

3. All medical Appeals are referred to the CMO or his or her Designee who has the authority to require corrective action, is of the same or similar specialty, is able to treat complications that may result from the service or procedure, and did not make the initial utilization management decision.

4. CalOptima shall utilize specialist consultants as appropriate.

5. UM Post-service Appeals Resolution

   a. CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal

   b. If CalOptima completely overturns the decision, the Notice of Appeal Resolution shall state the decision and the date of the decision. CalOptima shall also ensure the written response sent to the appealing party contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

   c. If CalOptima does not completely overturn the decision, such written notice shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits pending a State Hearing, and the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when he or she appeals.

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d. If CalOptima upholds a UM Appeal decision, in whole or in part, the Notice of Appeal Resolution shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member,

or at a minimum, must include:

i. The Member's right to request a State Fair Hearing;

ii. How to request a State Fair Hearing;

iii. The right to continue to receive benefits pending a State Fair Hearing (Aid Paid Pending);

iv. How to request the continuation of benefits (Aid Paid Pending) and requirements to file a continuation within ten (10) calendar days of when the NABD/NOA was sent or before the intended effective date of the proposed action; and

v. The DHCS-approved "Your Rights" attachment.

e. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

F. External Appeals

1. CalOptima shall annually inform Members of the right to a State Hearing through the Medi-Cal Member Newsletter, including that the information is also available on the CalOptima Website at www.caloptima.org. CalOptima must also advise Members of their right to file an expedited State Hearing.

2. CalOptima shall include written or electronic notifications to Members in the resolution letter detailing the State Hearing rights, time limitations and processes, including the contact information for the California Department of Social Services.

3. In the event CalOptima fails to meet or respond to the thirty (30) calendar day resolution timeline or comply with the notice requirements of Title 42 C.F.R. section 438.10, the Member is deemed to have exhausted CalOptima's internal Appeal Process and may initiate a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

4. A Member eligible with California Children's Services (CCS) and transitioned into the Whole-Child Model (WCM) Program, the Member's family or designated caregiver may appeal a Continuity of Care limitation, in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and this Policy.

G. In addition to any rights set forth in this Policy, a Member shall also have the right to:

1. Request that CalOptima provide assistance to Members when completing Appeal forms and other procedural steps, including but not limited to, providing all documents relied on for CalOptima's decision to the Member, and providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services, for assistance in the Appeal Process, or to provide translation of Appeal correspondence; and

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2. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

3. CalOptima shall inform a Member of these rights annually, and in every Notice of Appeal Resolution letter.

H. Responsible staff-

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Appeal Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Appeal Process.

I. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations and telephone numbers where an Appeal should be submitted, and related procedures regarding these processes. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Appeal, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall continually evaluate and analyze Appeal data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.

4. CalOptima shall submit a monthly report of complete, accurate, reasonable, and timely aggregated Appeal data within ten (10) calendar days following the end of each month or as otherwise agreed upon by DHCS, and in the format specified with DHCS, in accordance with this Policy and CalOptima Policy AA.1270: Certification of Document and Data Submissions.

5. CalOptima shall submit, on a quarterly basis, aggregate and detailed Appeals data to the Quality Assurance Committee.

6. CalOptima shall submit a report of Appeals related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Appeals or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Appeal was reported to the County of Orange or MSSP site.

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7. CalOptima shall establish and maintain a system of aging of Appeals that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1270: Certification of Document and Data Submissions
C. CalOptima Policy DD.2002: Cultural and Linguistic Services
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
F. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
G. CalOptima Policy GG.1611: Potential Quality Issue Review Process
H. CalOptima Policy HH.1101: CalOptima Provider Complaint
I. CalOptima Policy HH.1102: Member Grievance
J. CalOptima Policy HH.1104: Complaints of Discrimination
K. CalOptima Policy HH.1108: State Hearing Process and Procedures
L. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
M. CalOptima Member Handbook
N. Department of Health Care Services All Plan Letter (APL) 20-017: Requirements for Reporting Managed Care Program Data
O. Department of Health Care Services All Plan Letter (APL) 20-020: Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
P. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Template
Q. Title 22, California Code of Regulations (C.C.R.), §§ 51014.2, and 53858
R. Title 28, California Code of Regulations (C.C.R.), § 1300.68 (except Subdivision 1300.68(c)(g) and (h)), and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
S. Title 42, Code of Federal Regulations (C.F.R.), § 438.10, 438.402-424

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/22/2015	Department of Health Care Services (DHCS)	Approved as Submitted
02/03/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/1995	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/1998	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	05/1999	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	08/01/2004	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2007	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	06/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2011	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2012	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	09/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	11/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	04/01/2016	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/07/2019	GG.1510	Appeal Process	Medi-Cal
Revised	05/01/2021	GG.1510	Appeal Process	Medi-Cal
Revised	TBD	GG.1510	Member Appeal Process	Medi-Cal

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IX. GLOSSARY

Term	Definitions
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.
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).
Adverse Benefit Determination	Any of the following actions taken by CalOptima: 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 MCP, 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.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member’s parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
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.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.

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Term	Definitions
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 not-withstanding 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.
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.
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.

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Term	Definitions
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.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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.
State Hearing	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.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Utilization Management (UM) Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.

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<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

For 20220505 BOD Review for Retirement

[CalOptima logo]

"Uphold"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf]* appealed the *[denial, delay, modification, or termination]* of *[Service requested]*.

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to uphold the decision. This request is still denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>*.

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you need help reading this letter or have any questions, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff

For 20220505 BOD Review for Retirement

who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

For 20220505 BOD Review for Retirement

[CalOptima logo]

"Overturn"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf],* appealed the *[denial, delay, modification, or termination]* of *[Service requested].*

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision].*

[CalOptima] has 72 hours to approve or provide you the service.

Your request has been approved *[under authorization number <#> from <date> to <date> with <provider> or payment has been made].* On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

If you need help reading this letter or have any questions, please call, *[Grievance and Appeals Resolution Services Staff Name],* at *[telephone number].*

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

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The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

Grievance and Appeals

For 20220505 BOD Review for Retirement

Policy:	HH.1102
Title:	**Member Grievance**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Grievances from a Member, or a ~~Member's~~Provider or Authorized Representative~~,~~ acting on behalf of a Member and with the Member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall establish and maintain a Grievance Process pursuant to which a Member, or a ~~Member's~~Provider or Authorized Representative~~, or provider~~ acting on behalf of ~~the~~a Member and with the Member's written consent, may submit a Grievance for review and Resolution either orally or in writing.

B. CalOptima's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the complaint shall still be categorized as a Grievance.

D. CalOptima shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.

E. CalOptima shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance or may manage a Grievance under the supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

F. CalOptima shall process expedited requests timely in instances where a ~~provider~~Provider indicates, or CalOptima determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

G. CalOptima shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and he or she is not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited

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resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

H. CalOptima shall refer all potential medical quality of care issues identified through the Grievance Process to the Quality Improvement Department for review~~.~~.

I. CalOptima shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or ~~provider~~Provider on the grounds that he or she filed a Grievance as required by federal and state nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

J. CalOptima and a Health Network shall inform a Member of their right to file a Grievance through CalOptima at any time to express dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this ~~policy.~~ Policy.

a. A Member's Provider or Authorized Representative ~~or provider~~, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance at any time.

~~K. CalOptima and a Health Network shall inform a Member of their right to file an Appeal in accordance with CalOptima Policy GG.1510: Appeal Process.~~

~~L.~~K. CalOptima and a Health Network shall inform a Member, during the Grievance Process, of their right to request a State Hearing after the Appeal process, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State ~~Hearings~~Hearing Process and Procedures, GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and GG.1510: ~~Member~~ Appeal Process.

~~M. CalOptima shall allow a Member, a Member's Authorized Representative or provider, acting on behalf of the Member with the Member's written consent, to file a Grievance when he or she disagrees with a decision to extend the timeframe for resolution of an Appeal or expedited Appeal.~~

~~N.~~L. CalOptima shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. CalOptima and a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances.

~~O.~~M. CalOptima shall consider all comments, documents, records, and other information submitted by the Member or the Member's Authorized Representative, regardless of whether such information was submitted or considered during the initial review.

~~P.~~N. CalOptima shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Records, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or ~~the Member's~~ a Provider or Authorized Representative~~, or provider~~ acting on behalf of the Member and with the Member's written consent. CalOptima shall provide records at no cost.

~~Q.~~O. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, including language assistance taglines and a notice of non-discrimination in compliance with the requirements set forth by the Department of Health Care

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Services (DHCS), and in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

P. ~~CalOptima~~A Member, or a Provider or Authorized Representative acting on behalf of the Member and ~~a~~with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS. Such request shall be considered a Non-Coverage Appeal and CalOptima shall process the request as a Grievance and in accordance with Section III.C. of this Policy.

~~R.~~Q. In general, the Member Grievance process is not delegated to Health Networks, however, CalOptima may delegate the Member Grievance process to a contracted Health Maintenance Organization. Such delegated Health Network shall ~~inform a Member of their right to file a Grievance with CalOptima or with the Secretary of Health and Human Services regarding violations of their privacy rights,~~conduct the Member's Grievance process in accordance with CalOptima Policy HH.~~3020A: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.~~1103: Health Network Member Grievance and Appeal Process and in compliance with applicable regulatory and contractual requirements.

~~S. CalOptima shall process Exempt Grievances in accordance with CalOptima Policy DD.2013: Customer Service Grievance Process.~~

~~T. CalOptima shall process a Grievance for discrimination in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.~~

~~5. Grievances for Pharmacy Services~~

~~1. CalOptima shall process Grievances for pharmacy services rendered or requested on or before implementation of Medi-Cal Rx, in accordance with this Policy.~~

~~2. For Grievances received in the GARS Department for pharmacy services that are part of the Medi-Cal Rx transition, CalOptima shall refer such Grievances received to the Medi-Cal Rx Customer Service Center within three (3) calendar days pursuant to the Medi-Cal Rx transition requirements.~~

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing a Grievance available to facilities that provide Covered Services to Members.

2. CalOptima shall promptly provide complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances and shall triage Member calls and route Grievances to the GARS Department via its electronic system.

4. CalOptima shall ~~provide reasonable~~ ensure that Members accessing the Grievance system are given assistance ~~to Members~~ in completing Grievance forms and other procedural steps, including but not limited to, providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

B. Grievance Process

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1. A Member, or a ~~Member's~~Provider or Authorized Representative~~, or provider~~ acting on behalf of the Member and with the Member's written consent, may file a Grievance:

   a. With CalOptima's Customer Service Department, by telephone, or in person; or

   b. With CalOptima GARS, by facsimile, in writing, or through the CalOptima website at www.caloptima.org.

   c. CalOptima shall provide language assistance, by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

   d. In the event an oral Grievance is received, CalOptima will process the Grievance regardless of whether ~~or not~~ a signed, written ~~confirmation~~Grievance is subsequently received from the Member.

   e. CalOptima shall process Exempt Grievances in accordance with CalOptima Policy DD.2013: Customer Service Grievance Process.

   f. CalOptima shall process a Grievance for discrimination as required by federal and State nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

2. GARS shall:

   a. Date stamp and document the substance of the Grievance, and any action taken, in the GARS database, verifying demographics and network affiliation.

   b. Determine the category of Grievance, including but not limited to the following categories: quality of care, quality of service, access to care, and other, based on the Grievance. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

   c. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance, the date of receipt of the Grievance, and providing the name, telephone number and address of the GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

   d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Grievance.

   e. Refer all Grievances related to potential medical quality of care issues to the Quality Improvement (QI) Department for immediate review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process~~.~~ in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

   f. Review and immediately process all Grievances that may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited Grievance as required in the CalOptima contract with DHCS.

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g. Escalate the Grievance for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix and shall issue a decision with respect to the Grievance.

h. Send the Member, ~~a Member's~~or Provider or Authorized Representative~~, or provider~~ acting on behalf of the Member and with the Member's written consent, a Grievance Resolution Letter, not to exceed thirty (30) calendar days from the date CalOptima receives the oral or written Grievance~~.~~ In the event that GARS is unable to resolve the Member's concern within the required thirty (30) calendar days, written notification will be sent to the Member to provide the status and estimated date of Resolution (not to exceed fourteen (14) calendar days).

~~i. For a standard Grievance, in the event the Resolution is not reached in thirty (30) days, notify the Member in writing of the status of the Grievance and provide an estimated completion date of Resolution, which shall not exceed fourteen (14) calendar days.~~

~~j.~~i. Translate Grievance correspondence into Threshold Languages, and offer oral interpretation for Grievance correspondence for all other languages; and

~~k.~~j. Provide an interpreter, or auxiliary aide, for assistance in the Grievance Process.

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

   a. Summary of the Member's Grievance;

   b. The investigation made in the review process, including any referrals to the Quality Improvement Department for medical quality of care review;

   c. When possible, the outcome of the review;

   d. Alternative resources or references, when applicable; and

   e. The Member's right to Appeal, as appropriate.

4. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

5. Grievances for Pharmacy Services

   a. CalOptima shall process Grievances for pharmacy services rendered or requested before the implementation of Medi-Cal Rx, in accordance with this Policy.

   b. For Grievances received in writing in the GARS Department for pharmacy services that are part of the Medi-Cal Rx transition, CalOptima shall refer such Grievances received to the Medi-Cal Rx Customer Service Center within three (3) calendar days pursuant to the Medi-Cal Rx transition requirements.

6. Grievances Related to Privacy Rights

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a. CalOptima and a Health Network shall inform a Member of their right to file a Grievance with CalOptima or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

C. Non-Coverage Appeals

1. A Member, or a Provider or Authorized Representative~~, or provider~~ acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of Grievance is considered a Non-Coverage Appeal and is separate from the Appeal process in CalOptima Policy GG.1510: Appeal Process.

2. A Member, or a Provider or Authorized Representative~~, or provider~~ acting on behalf of the Member and with the Member's written consent, may file the Non-Coverage Appeal with CalOptima's Customer Service Department by telephone or in person~~;~~, or with GARS via facsimile, in writing or through the CalOptima Website at www.caloptima.org.

3. CalOptima shall provide language assistance by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

5. Upon receipt of the Non-Coverage Appeal GARS shall:

   a. Date stamp and document the substance of the Non-Coverage Appeal, and any action taken, into its electronic system, verifying demographics and network affiliation;

   b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Non-Coverage Appeal;

   d. Triage and investigate the Non-Coverage Appeals and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Complaint;

   e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Chief CMO or their Designee and any action deemed necessary under the quality review process;

   f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt;

   g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance.

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i. CalOptima shall translate Grievance Resolution Letters into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter, written in English, for all other languages.

ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests to be in CalOptima Direct - Administrative, and for access to out-of-network ~~providers~~Providers or change of Health Networks, the resolution letter shall include:

1) Summary of the Member's Non-Coverage Appeal;

2) Description of actions taken to review the request;

3) Date and name of position of staff involved in the review; and

4) Date of the issuance of the decision.

6. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Resolution Letter and document any oral notification provided to the Member, and resolution date.

D. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

a. Maintenance of the Grievance Process;

b. Review of the operations; and

c. ~~Review~~Identification of any emerging or systemic issues ~~of~~ Grievances and Appeals and/or patterns of ~~Grievances~~ improper service denials in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

E. Notices, Records and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, and related procedures regarding the Grievance Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with DHCS.

2. CalOptima shall maintain and make accessible to DHCS, and, upon request, have available for the Centers for Medicare & Medicaid Services, written records of each Grievance, including copies of Grievance records of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances. The records shall include the date and time of receipt, Member's name, description of the complaint or problem, names of the CalOptima staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, ~~proposed~~ resolution~~,~~ proposed by GARS or the

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medical professional responsible for making utilization management decision, the name of the CalOptima provider or staff responsible for resolving the Grievance, the date of notification to the Member of resolution, and all Grievance Resolution Letters ~~and Notice of Appeal Resolution letters~~. CalOptima shall maintain the written records, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with the DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall continually evaluate and analyze Grievance data to identify systemic ~~patters~~patterns of improper services denials and other trends impacting health care delivery to Members.

4. On a quarterly basis, CalOptima shall submit all recorded Member Grievances related to access to care, quality of care and denial of services to the Quality Improvement Committee (QIC) to review and take appropriate action to remedy any problems identified in such reviews.

5. CalOptima shall submit a monthly report of complete, accurate, reasonable, and timely aggregated Grievance data within ten (10) calendar days following the end of each month or as otherwise agreed upon by DHCS, and in the format specified ~~by~~with DHCS, in accordance with this Policy and CalOptima Policy AA.1270: Certification of Document and Data Submissions.

6. CalOptima shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

7. CalOptima shall submit a report of Grievances related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Grievances or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Grievance was reported to the County of Orange or MSSP site.

8. CalOptima shall establish and maintain a system of aging of Grievances that are pending and unresolved for thirty (30) calendar days or more~~.~~ and include a brief explanation of the reasons for each pending and unresolved Grievance.

IV. ATTACHMENT(S)

~~A. Acknowledgement Letter~~
~~B. Grievance Resolution Letter~~

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1270: Certification of Document and Data Submissions
C. CalOptima Policy DD.2002: Cultural and Linguistic Services
D. CalOptima Policy DD.2013: Customer Service Grievance Process
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510: Appeal Process
G. CalOptima Policy GG.1611: Potential Quality Issue Review Process
~~G.~~H. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
~~H.~~I. CalOptima Policy HH.1104: Complaints of Discrimination
~~I.~~J. CalOptima Policy HH.1108: State Hearings Process and Procedures
~~J.~~K. CalOptima Policy HH.1109: Complaint Decision Matrix

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~~K.~~L. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

~~L.~~M. Department of Health Care Services All Plan Letter ~~17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments~~(APL) 20-017: Requirements for reporting Managed Care Program Data

~~M.~~N. Department of Health Care Services All Plan Letter (APL) 20-020: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx

O. Department of Health Care Services All Plan Letter (APL) 20-022: COVID-19 Vaccine Administration

P. Department of Health Care Services All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

Q. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates

R. Standards and Guidelines for the Accreditation of Health Plans

~~N.~~S. Title 22, California Code of Regulations (C.C.R.), §53858

~~O.~~T. Title 22, California Code of Regulations (C.C.R.), §53858 (e)

~~P.~~U. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))

~~Q.~~V. Title 42, Code of Federal Regulations (C.F.R.), §438.3(u)

~~R.~~W. Title 42, Code of Federal Regulations (C.F.R.), §§438.402, 406, 408, and 416

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/29/2015	Department of Health Care Services (DHCS)	Approved as Submitted
12/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1996	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2000	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2001	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	03/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2004	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2011	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2013	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	02/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	03/07/2019	HH.1102	Member Grievance	Medi-Cal
Revised	04/01/2021	HH.1102	Member Grievance	Medi-Cal
Revised	TBD	HH.1102	Member Grievance	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	~~Denial,~~Any of the following actions taken by CalOptima or a Health Network: 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 ~~requested~~previously authorized service~~, including~~. 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 ~~a decision~~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. ~~1.~~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.
Appeal	A review by CalOptima of an ~~adverse benefit determinations~~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~~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).
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance.
~~Grievance Process~~	~~The process by which CalOptima and its Health Networks address and provide resolution to all Grievances.~~
~~Grievance Resolution Letter~~	~~A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.~~

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Term	Definition
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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 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.
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.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an ~~adverse benefit determination~~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.
Grievance Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
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.
In-Home Supportive Services (IHSS)	Services provided to Members by the County in accordance with the requirements set forth in Welfare & Institutions Code Section 14186.1(c)(1), and Article 7 of the Welfare & Institutions Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.
Long Term Care (LTC)	Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.
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.

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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.
Multipurpose Senior Service Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.
Non-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
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.
Resolution	The grievance has reached a final conclusion with respect to the Member or Provider's submitted grievance.
State Hearing	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.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

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Policy:	HH.1102
Title:	**Member Grievance**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Grievances from a Member, or a Provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall establish and maintain a Grievance Process pursuant to which a Member, or a Provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, may submit a Grievance for review and Resolution either orally or in writing.

B. CalOptima's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the complaint shall still be categorized as a Grievance.

D. CalOptima shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.

E. CalOptima shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance or may manage a Grievance under the supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

F. CalOptima shall process expedited requests timely in instances where a Provider indicates, or CalOptima determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

G. CalOptima shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and he or she is not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

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H. CalOptima shall refer all potential medical quality of care issues identified through the Grievance Process to the Quality Improvement Department for review.

I. CalOptima shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that he or she filed a Grievance as required by federal and state nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

J. CalOptima and a Health Network shall inform a Member of their right to file a Grievance through CalOptima at any time to express dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this Policy.

   a. A Member's Provider or Authorized Representative, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance at any time.

K. CalOptima and a Health Network shall inform a Member, during the Grievance Process, of their right to request a State Hearing after the Appeal process, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearing Process and Procedures, GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and GG.1510: Appeal Process.

L. CalOptima shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. CalOptima and a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances.

M. CalOptima shall consider all comments, documents, records, and other information submitted by the Member or the Member's Authorized Representative, regardless of whether such information was submitted or considered during the initial review.

N. CalOptima shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Records, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent. CalOptima shall provide records at no cost.

O. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, including language assistance taglines and a notice of non-discrimination in compliance with the requirements set forth by the Department of Health Care Services (DHCS), and in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

P. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS. Such request shall be considered a Non-Coverage Appeal and CalOptima shall process the request as a Grievance and in accordance with Section III.C. of this Policy.

Q. In general, the Member Grievance process is not delegated to Health Networks, however, CalOptima may delegate the Member Grievance process to a contracted Health Maintenance

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Organization. Such delegated Health Network shall conduct the Member's Grievance process in accordance with CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process and in compliance with applicable regulatory and contractual requirements.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing a Grievance available to facilities that provide Covered Services to Members.

2. CalOptima shall promptly provide complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances and shall triage Member calls and route Grievances to the GARS Department via its electronic system.

4. CalOptima shall ensure that Members accessing the Grievance system are given assistance in completing Grievance forms and other procedural steps, including but not limited to, providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

B. Grievance Process

1. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may file a Grievance:

   a. With CalOptima's Customer Service Department, by telephone, or in person; or

   b. With CalOptima GARS, by facsimile, in writing, or through the CalOptima website at www.caloptima.org.

   c. CalOptima shall provide language assistance, by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

   d. In the event an oral Grievance is received, CalOptima will process the Grievance regardless of whether a signed, written Grievance is subsequently received from the Member.

   e. CalOptima shall process Exempt Grievances in accordance with CalOptima Policy DD.2013: Customer Service Grievance Process.

   f. CalOptima shall process a Grievance for discrimination as required by federal and State nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

2. GARS shall:

   a. Date stamp and document the substance of the Grievance, and any action taken, in the GARS database, verifying demographics and network affiliation.

   b. Determine the category of Grievance, including but not limited to the following categories: quality of care, quality of service, access to care, and other, based on the Grievance. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

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c. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance, the date of receipt of the Grievance, and providing the name, telephone number and address of the GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Grievance.

e. Refer all Grievances related to potential medical quality of care issues to the Quality Improvement (QI) Department for immediate review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

f. Review and immediately process all Grievances that may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited Grievance as required in the CalOptima contract with DHCS.

g. Escalate the Grievance for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix and shall issue a decision with respect to the Grievance.

h. Send the Member, or Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, a Grievance Resolution Letter, not to exceed thirty (30) calendar days from the date CalOptima receives the oral or written Grievance In the event that GARS is unable to resolve the Member's concern within the required thirty (30) calendar days, written notification will be sent to the Member to provide the status and estimated date of Resolution (not to exceed fourteen (14) calendar days).

i. Translate Grievance correspondence into Threshold Languages, and offer oral interpretation for Grievance correspondence for all other languages; and

j. Provide an interpreter, or auxiliary aide, for assistance in the Grievance Process.

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a. Summary of the Member's Grievance;

b. The investigation made in the review process, including any referrals to the Quality Improvement Department for medical quality of care review;

c. When possible, the outcome of the review;

d. Alternative resources or references, when applicable; and

e. The Member's right to Appeal, as appropriate.

4. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, reviewing entity(ies), decision and any additional action taken (if any), include a

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copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

5. Grievances for Pharmacy Services

   a. CalOptima shall process Grievances for pharmacy services rendered or requested before the implementation of Medi-Cal Rx, in accordance with this Policy.

   b. For Grievances received in writing in the GARS Department for pharmacy services that are part of the Medi-Cal Rx transition, CalOptima shall refer such Grievances received to the Medi-Cal Rx Customer Service Center within three (3) calendar days pursuant to the Medi-Cal Rx transition requirements.

6. Grievances Related to Privacy Rights

   a. CalOptima and a Health Network shall inform a Member of their right to file a Grievance with CalOptima or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

C. Non-Coverage Appeals

1. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of Grievance is considered a Non-Coverage Appeal and is separate from the Appeal process in CalOptima Policy GG.1510: Appeal Process.

2. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may file the Non-Coverage Appeal with CalOptima's Customer Service Department by telephone or in person, or with GARS via facsimile, in writing or through the CalOptima Website at www.caloptima.org.

3. CalOptima shall provide language assistance by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

5. Upon receipt of the Non-Coverage Appeal GARS shall:

   a. Date stamp and document the substance of the Non-Coverage Appeal, and any action taken, into its electronic system, verifying demographics and network affiliation;

   b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Non-Coverage Appeal;

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d. Triage and investigate the Non-Coverage Appeals and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Complaint;

e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Chief CMO or their Designee and any action deemed necessary under the quality review process;

f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt;

g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance.

i. CalOptima shall translate Grievance Resolution Letters into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter, written in English, for all other languages.

ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests to be in CalOptima Direct - Administrative, and for access to out-of-network Providers or change of Health Networks, the resolution letter shall include:

1) Summary of the Member's Non-Coverage Appeal;

2) Description of actions taken to review the request;

3) Date and name of position of staff involved in the review; and

4) Date of the issuance of the decision.

6. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Resolution Letter and document any oral notification provided to the Member, and resolution date.

D. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

a. Maintenance of the Grievance Process;

b. Review of the operations; and

c. Identification of any emerging or systemic issues of Grievances and Appeals and/or patterns of improper service denials in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

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E. Notices, Records and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, and related procedures regarding the Grievance Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with DHCS.

2. CalOptima shall maintain and make accessible to DHCS, and, upon request, have available for the Centers for Medicare & Medicaid Services, written records of each Grievance, including copies of Grievance records of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances. The records shall include the date and time of receipt, Member's name, description of the complaint or problem, names of the CalOptima staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, resolution proposed by GARS or the medical professional responsible for making utilization management decision, the name of the CalOptima provider or staff responsible for resolving the Grievance, the date of notification to the Member of resolution, and all Grievance Resolution Letters . CalOptima shall maintain the written records, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with the DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall continually evaluate and analyze Grievance data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.

4. On a quarterly basis, CalOptima shall submit all recorded Member Grievances related to access to care, quality of care and denial of services to the Quality Improvement Committee (QIC) to review and take appropriate action to remedy any problems identified in such reviews.

5. CalOptima shall submit a monthly report of complete, accurate, reasonable, and timely aggregated Grievance data within ten (10) calendar days following the end of each month or as otherwise agreed upon by DHCS, and in the format specified with DHCS, in accordance with this Policy and CalOptima Policy AA.1270: Certification of Document and Data Submissions.

6. CalOptima shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

7. CalOptima shall submit a report of Grievances related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Grievances or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Grievance was reported to the County of Orange or MSSP site.

8. CalOptima shall establish and maintain a system of aging of Grievances that are pending and unresolved for thirty (30) calendar days or more and include a brief explanation of the reasons for each pending and unresolved Grievance.

IV. ATTACHMENT(S)

Not Applicable

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V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1270: Certification of Document and Data Submissions
C. CalOptima Policy DD.2002: Cultural and Linguistic Services
D. CalOptima Policy DD.2013: Customer Service Grievance Process
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510: Appeal Process
G. CalOptima Policy GG.1611: Potential Quality Issue Review Process
H. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
I. CalOptima Policy HH.1104: Complaints of Discrimination
J. CalOptima Policy HH.1108: State Hearings Process and Procedures
K. CalOptima Policy HH.1109: Complaint Decision Matrix
L. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
M. Department of Health Care Services All Plan Letter (APL) 20-017: Requirements for reporting Managed Care Program Data
N. Department of Health Care Services All Plan Letter (APL) 20-020: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
O. Department of Health Care Services All Plan Letter (APL) 20-022: COVID-19 Vaccine Administration
P. Department of Health Care Services All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
Q. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
R. Standards and Guidelines for the Accreditation of Health Plans
S. Title 22, California Code of Regulations (C.C.R.), §53858
T. Title 22, California Code of Regulations (C.C.R.), §53858 (e)
U. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
V. Title 42, Code of Federal Regulations (C.F.R.), §438.3(u)
W. Title 42, Code of Federal Regulations (C.F.R.), §§438.402, 406, 408, and 416

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/29/2015	Department of Health Care Services (DHCS)	Approved as Submitted
12/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1996	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2000	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2001	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	03/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2004	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2011	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2013	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	02/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	03/07/2019	HH.1102	Member Grievance	Medi-Cal
Revised	04/01/2021	HH.1102	Member Grievance	Medi-Cal
Revised	TBD	HH.1102	Member Grievance	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Any of the following actions taken by CalOptima or a Health Network: 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.
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).
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member’s parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance.

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Term	Definition
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program 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 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.
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.
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.
Grievance Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
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.
In-Home Supportive Services (IHSS)	Services provided to Members by the County in accordance with the requirements set forth in Welfare & Institutions Code Section 14186.1(c)(1), and Article 7 of the Welfare & Institutions Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.
Long Term Care (LTC)	Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.
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.

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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.
Multipurpose Senior Service Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.
Non-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
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.
Resolution	The grievance has reached a final conclusion with respect to the Member or Provider's submitted grievance.
State Hearing	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.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

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<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear <Member Name>:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or phone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date we received it.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call <SPECIALIST NAME>, Resolution Specialist at <**PHONE NUMBER**>. You may also examine the papers related to your [grievance or appeal] before and during the [grievance or appeal] process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima Customer Service at **1-714-246-8500**, or toll-free at **1-888-587-8088** (TTY **711**), Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. You can also visit our website at **www.caloptima.org**.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

Enclosures:
Notice of Nondiscrimination
Language Assistance Taglines

For 20220505 BOD Review for Retirement

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TTY: 711

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<DATE>

<FIRST AND LAST NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <Member Name>:

This letter is in response to your complaint filed on <insert the date filed> about <insert the member's issue(s) or concern(s)>. Thank you for taking the time to share your concerns with us. We are sorry for any trouble this may have caused you.

In your complaint, you stated <insert the member's statement>.

<STANDARD GRIEVANCE> Our Grievance and Appeals Resolution Services department reviewed your complaint <summary of your investigation, outcomes, referrals, alternative resources or references when applicable including name(s) of person(s) contacted, department, medical group & any outcomes that are relevant to member not subject to peer review protection>.

<QUALITY OF CARE INSERT:> I have also referred your concerns to CalOptima's Quality Improvement (QI) department to review the health care you received. The reason for this review is to decide if the health care provided meets the professional standards in the community. You will receive an acknowledgment letter from our QI department explaining the review process. The review process normally takes 120 days to complete. If the standards have been met, no further action is needed. If not, CalOptima will take the correct action necessary. California law does not let us share the details of this review.

CalOptima will take all required actions to solve your concerns. All concerns by our members, including those that could be related to quality of care, fraud and abuse, quality of service or access to care problems are taken very seriously. We monitor these issues to look for ways to improve our programs and prevent future problems. It is our goal to provide access to quality care and services to our members.

Your input is important to us, and we are here to help you with your health care needs. If you have questions or concerns about this letter, please call me at **<X-XXX-XXX-XXXX>**.

For future assistance or questions about your benefits, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088** (TTY **711**), Monday through

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 711

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Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. You can also visit our website at **www.caloptima.org**.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

Enclosures:
Notice of Nondiscrimination
Language Assistance Taglines

For 20220505 BOD Review for Retirement

Policy:	HH.1103
Title:	**Health Network Member Grievance and Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in the Health Network as delegated by CalOptima, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

II. POLICY

A. CalOptima may ~~authorize a Health Network to manage~~delegate Grievances and Appeals functions to a Health Network for Members enrolled in that Health Network.

B. If CalOptima authorizes a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network:

1. The Health Network shall establish and maintain a Grievance and Appeals Process pursuant to which a Member, or a ~~Member's~~provider or Authorized Representative~~, or provider~~ acting on behalf of ~~the~~a Member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution.

2. The Grievances and Appeals Process shall address the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with ~~applicable statutory, regulatory, and contractual requirements.~~the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters.

3. The Health Network shall ensure prompt review and investigation of ~~a Grievance or Appeal by management or supervisory staff responsible for the services or operations that are the subject of the~~ Member Grievances or Appeals~~.~~ by the appropriate department and/or staff delegated the responsibility to handle the Health Network's internal Grievance and Appeals operations.

4. The Health Network shall ensure that ~~the person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is~~ every Grievance submitted by a ~~subordinate of someone who has participated in~~ Member, or a ~~prior decision~~provider or Authorized Representative acting on behalf of a Member and ~~has clinical expertise in treating~~with the Member's ~~condition or disease if deciding on any~~written

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consent, is reported to an appropriate level within the Health Network (i.e., quality of care versus quality of ~~the following:~~service).

~~i. An Appeal of a denial based on lack of Medical Necessity;~~

~~ii.~~i. ~~A Grievance regarding denial of an expedited resolution of an Appeal; and~~

~~a. Any Grievance or Appeal involving clinical issues.~~

~~b.~~a. The Health Network shall immediately refer all medical quality of care issues to the Health Network's Medical Director or Designee for review.

5. The Health Network shall ~~ensure that there is no discrimination~~ not discriminate or retaliate against ~~a~~any Member, a Member's Authorized Representative, or a provider on ~~the~~ grounds that ~~the Member~~he or she filed a Grievance or Appeal as required by federal and State nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

~~b.~~a. ~~The Health Network shall ensure that its Members are informed of their right to Appeal a Health Network Utilization Management (UM) decision by filing a UM Appeal with the Health Network within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) that denied, delayed, or modified a request for services.~~

~~2. The Member has the right to request an Appeal in the event that a Health Network fails to issue a NABD/NOA within the required time frame, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination.~~

6. The Health Network shall forward Grievances alleging discrimination to CalOptima Grievances and Appeals Resolution Services for timely submission to the Department of Health Care Services (DHCS) Office of Civil Rights (OCR) pursuant to CalOptima Policy HH.1104: Complaints of Discrimination.

C. The Health Network shall inform a Member, ~~the Member's~~or a provider or Authorized Representative~~, or Provider,~~ acting on behalf of ~~the~~a Member and with the Member's written consent, of his or her right to file a Grievance at any time regarding an incident or issue that caused the Member's dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) through CalOptima or the Health Network, in accordance with the provisions of this policy.

D. The Health Network shall inform a Member, ~~the Member's~~or a provider or Authorized Representative~~, or provider,~~ acting on behalf of ~~the~~a Member and with the Member's written consent, during the Appeal Process, of his or her right to request a State Hearing after the Appeal Process has been exhausted or if the Health Network fails to send a resolution notice with thirty (30) calendar days of the Appeal being filed with the Health Network (deemed exhaustion), and of his or her right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearing Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. The Health Network shall allow a Member, or a ~~Member's~~provider or Authorized Representative ~~or provider,~~ acting on behalf of ~~the~~a Member and with the Member's written consent, to file a Grievance when he or she disagrees with a decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

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F. The Health Network shall process Grievances and Appeals for pharmacy services rendered or requested before implementation of Medi-Cal Rx, in accordance with Section III.A.5. of this Policy.

III. PROCEDURE

A Health Network

~~F. The Health Network shall give a Member, the Member's Authorized Representative, or provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Grievance or Appeal, evidence, testimony, facts and law in support of his or her Grievance or Appeal. CalOptima and the Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances and Appeals.~~

~~G. The Health Network consider all comments, documents, records, and other information submitted by the Member or the Member's Authorized Representative, regardless of whether such information was submitted or considered during the initial review.~~

A. delegated Grievances and Appeals functions for Members enrolled in that Health Network pursuant to Section II.B. of this Policy, shall maintain a Grievance and Appeal Process as follows:

~~H. The Health Network shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by the Member, his or her Authorized Representative, or provider, acting on behalf of the Member with the Member's written consent, at no cost.~~

~~I.A. The Health Network shall assist a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs as provided for in Section III.A.6.a of this Policy.~~

1. Filing a Grievance or Appeal

a. A Member or a Member's Authorized Representative may file a Grievance or Appeal with the Member's Health Network, orally and/or in writing by telephone, in person, or facsimile.

b. A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The Health Network shall grant the Member continuation of the benefit until an Appeal decision is reached.

c. The Health Network shall ensure that its Members are informed of their right to Appeal a Health Network Utilization Management (UM) decision by filing a UM Appeal with the Health Network within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) that denied, delayed, or modified a request for services.

d. In the event that a Health Network fails to issue a NABD/NOA within the required time frame, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination such that the Member has the right to request an Appeal.

~~e.~~e. The Health Network shall inform a Member of his or her right to file a Grievance with CalOptima, the Health Network, or the Secretary of Health and Human Services regarding

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violations of the Member's privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

~~J. The Health Network shall not discriminate or retaliate against any Member, a Member's Authorized Representative, or a provider on grounds that such Member filed a Grievance or Appeal.~~

~~2.~~1. ~~Grievances for Pharmacy Services~~

~~1. The Health Network shall process Grievances and Appeals for pharmacy services rendered or requested on or before implementation of Medi-Cal Rx, in accordance with this Policy.~~

~~a. For Grievances received by the Health Network for pharmacy services rendered on or after the implementation of Medi-Cal Rx, the Health Network shall refer such Grievances received in writing to the Medi-Cal Rx Customer Service Center within three (3) calendar days pursuant to the Medi-Cal Rx transition requirements. For Grievances received via telephone, the Health Network shall refer the caller to the Medi-Rx Customer Service Center (CSC) telephone line pursuant to the Medi-Cal Rx transition requirements.~~

~~2. The Health Network shall categorize and track Grievances received for pharmacy services rendered on or after the implementation of Medi-Cal Rx, including those calls that are referred to, or transferred directly to, Medi-Cal Rx for at least sixty (60) calendar days as required by DHCS.~~

~~III. PROCEDURE~~

~~B. A Health Network~~ ~~authorized to manage Grievances and Appeals for Members enrolled in that Health Network pursuant to Section II.B. of this policy, shall maintain a Grievance and Appeal Process as follows:~~

~~1. Filing a Grievance or Appeal~~

~~a. A Member or a Member's Authorized Representative may file a Grievance or Appeal with the Member's Health Network, by telephone, in person, facsimile, or in writing.~~

~~b.~~a. ~~A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The Health Network shall grant the Member continuation of the benefit until an Appeal decision is reached.~~

~~c.~~f. Assistance to Members

i. The Health Network shall make the complaint forms and procedures for filing a Grievance or Appeal available to facilities that provide services to Members.

ii. The Health Network shall promptly provide the complaint forms and procedures to a Member upon request.

iii. The Health Network Member Services staff shall assist a Member with respect to the filing of a Grievance or Appeal.

iv. The Health Network shall provide assistance to a Member requiring assistance with filing a Grievance or Appeal and other procedural steps, including, but not limited to, a Member with ~~Limited~~limited English Proficiency ~~(~~LEP~~),~~, disabilities, or cultural needs~~.~~ as provided for in Section III.A.6.a. of this Policy.

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2. Acknowledgment of a Grievance or Appeal

a. Except as otherwise provided in Section III.A.4 of this policy, a Health Network shall send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance or Appeal indicating receipt of the Grievance or Appeal, the date of receipt of the Grievance or Appeal, ~~providing~~ the name, telephone number and address of the of the Grievance Resolution staff person whom the Member may contact regarding the Grievance or Appeal and the estimated completion date of resolution.

b. In instances of an oral Appeal request (excluding expedited Appeals) made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.

i. The date of the oral Appeal establishes the filing date for the Appeal.

ii. The Health Network will Process the Appeal whether or not a signed written Appeal confirmation is received from the Member Appeal.

c. A written confirmation does not apply to an oral grievance request.

d. If CalOptima receives a Member's Grievance or Appeal for a Health Network ~~that manages Grievances or~~delegated Grievance and Appeals responsibilities, CalOptima shall forward the Grievance or Appeal immediately to the Health Network ~~Complaint~~Member Grievance and Appeal staff for investigation and resolution.

3. Investigation and Resolution of a Grievance or Appeal

a. The Health Network ~~Complaint~~Member Grievance and Appeal staff shall promptly consult with the Health Network department responsible for the services or operations that are the subject of the Grievance or Appeal.

~~b.~~a. ~~If the Health Network denies a request for an expedited Resolution of an Appeal, the Health Network must process the request for an Appeal in accordance with the standard Appeal process timeframes as required in this Policy.~~

b. The Health Network ~~Complaint staff~~ shall ~~review the factual findings,~~ensure that the person making the final decision for the proposed resolution~~, and any other relevant information, and shall issue~~ of a Grievance ~~Resolution Letter~~ or ~~Notice of Appeal Resolution to respond~~Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

i. An Appeal of a denial based on lack of Medical Necessity or that the service is experimental/investigational;

ii. A Grievance regarding denial of an expedited resolution of an Appeal; and

~~i.~~iii. Any Grievance or Appeal~~.~~ involving clinical issues.

c. The Health Network shall give a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Grievance or Appeal, evidence, testimony, facts and law in support of his or her Grievance

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or Appeal. CalOptima and the Health Network shall inform a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances and Appeals.

d. The Health Network shall take into account all comments, documents, records, and other information submitted by the Member or the Member's Authorized Representative, regardless of whether such information was submitted or considered during the initial review.

e. The Health Network shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by ~~The Health Network shall send~~a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, at no cost.

~~e.~~f. The Health Network shall ensure timely written acknowledgement for each Grievance and request for an Appeal by sending the Member a Grievance Resolution Letter or Notice of Appeal Resolution as quickly as the Member's health condition requires, but not later than thirty (30) calendar days after receipt of an oral or written Grievance or Appeal, except as otherwise provided in Section III.A.4. of this ~~policy~~Policy.

~~d.~~g. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. Summary of the Member's Grievance;

ii. The investigation made in the review process, including any referrals to the Quality Improvement Department for a quality of care review;

iii. When possible, the outcome of the review;

iv. Alternative resources or references, when applicable;

~~e.~~h. The Notice of Appeal Resolution shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. The results of the resolution and the date it was completed;

ii. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

iii. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

iv. Alternative resources or references, when applicable;

v. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made; ~~and~~

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vi. The DHCS-approved "Your Rights" attachment~~.~~; and

vii. Language assistance taglines and a nondiscrimination notice meeting the minimum requirements of DHCS All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements.

~~f.~~i. The Health Network shall translate the Grievance Resolution Letter or Notice of Appeal Resolution into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter or Notice of Appeal Resolution for all other languages upon request.

~~g.~~j. The Health Network shall take action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

4. Expedited UM Appeal or Grievances

a. If the Health Network receives a Grievance or Appeal that involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function, it shall Process such Grievance or Appeals an Expedited UM Appeal or Grievance:

i. Upon receipt of the expedited review Appeal or Grievance information, the Health Network Chief Medical Officer (CMO), or his or her Designee, shall conduct a medical review.

ii. The Health Network shall utilize specialist consultants, as appropriate.

iii. The Health Network shall notify the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

iv. The Health Network shall make a decision on the Expedited UM Appeal or Grievance request as quickly as the medical condition requires, but no later than seventy-two (72) hours after the Expedited UM Appeal or Grievance request is made to the Health Network. The Health Network shall provide verbal notice of the resolution of the expedited review to the Member.

v. The Health Network shall notify the Member ~~or,~~ the Member's Authorized Representative, ~~and all involved Providers~~or provider that made the request on behalf of the CalOptima Member of the Expedited UM Appeal or Grievance decision ~~by facsimile~~through oral notice or ~~verbal communication~~in writing within seventy-two (72) hours after receiving the Expedited UM Appeal or Grievance. The Health Network shall provide a written notice within one (1) business day after ~~a verbal~~an oral notice.

b. The Health Network shall take immediate action to implement the decision, in accordance with the Expedited UM Appeal or Grievance decision.

c. If the Health Network denies a request for an expedited Resolution of an Appeal, the Health Network must process the request for an Appeal in accordance with the standard Appeal process timeframes as required in this Policy.

5. Grievances for Pharmacy Services

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a. For Grievances received by the Health Network for pharmacy services rendered upon the implementation of Medi-Cal Rx, the Health Network shall refer such Grievances received in writing to the Medi-Cal Rx Customer Service Center within three (3) calendar days pursuant to the Medi-Cal Rx transition requirements. For Grievances received via telephone, the Health Network shall refer the caller to the Medi-Rx Customer Service Center (CSC) telephone line pursuant to the Medi-Cal Rx transition requirements.

b. The Health Network shall categorize and track Grievances received for pharmacy services rendered upon the implementation of Medi-Cal Rx, including those calls that are referred to, or transferred directly to, Medi-Cal Rx for at least sixty (60) calendar days as required by DHCS.

~~5.~~6. In addition to any rights set forth in this Policy, a Member shall also have the right to:

a. Request the Health Network to provide ~~an~~assistance when completing Grievance and Appeal forms and other procedural steps, which includes, but is not limited to, providing all documents relied on for the Health Network's decision to the Member, and providing interpreter services or auxiliary aide(s) and a toll-free number with TTY/TDD and interpreter capability for assistance in the Grievance or Appeal ~~Process~~process, or to provide translation of Grievance or Appeal correspondence.

b. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State ~~Hearings~~Hearing Process and Procedures, and applicable laws.

i. The Health Network shall notify a Member of this right annually, and in every Acknowledgement and Resolution Letter.

ii. A Member may request a State Hearing within one hundred and twenty (120) calendar days after the Notice of Appeal Resolution~~.~~ (NAR).

iii. To request a State Hearing, a Member may:

a) ~~Write~~By Mail to:

California Department of Social Services
State Hearings Division
P. O. Box 944243, M.S. 19-37
Sacramento, CA 95814;

~~a)~~b)~~Call:~~ ~~(~~By Calling: 1-800~~) 952-5253~~-743-8525, or for TDD only, ~~(~~1-800~~)~~ -952-8349;

~~b)~~c)~~Facsimile:~~By Fax to: 1-916-~~651-5210,~~309-3487; or ~~916-651-2789; or~~

~~c) Present him or herself to the Department of Social Services at:~~

~~744 P Street~~
~~Sacramento, CA 95814~~

d) Online at www.cdss.ca.gov

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c. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.

d. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal Process and may initiate a State Hearing.

~~d.~~e. Upon notice from CalOptima that a Member filed for a State Hearing, a Health Network shall grant Aid Paid Pending, if applicable, until the State Hearing occurs, or a decision is rendered, in accordance with CalOptima Policies HH.1108: State ~~Hearings~~Hearing Process and Procedures and GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~.

~~d. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal Process and may initiate a State Hearing.~~

~~6.~~7. Responsible Staff

a. The Health Network shall designate ~~a manager~~an individual with authority to require corrective actions to be responsible for receiving Grievance or Appeal, issuing Grievance or Appeal decisions, and reporting to CalOptima.

b. The CalOptima Director of GARS or Designee shall have primary responsibility for the oversight of the Health Network Grievance and Appeal Process, including referring any non-compliance to the CalOptima Compliance Department for review and action, if needed.

~~c. CalOptima's Chief Operating Officer shall have primary responsibility for:~~

~~i. Maintenance of the Grievance or Appeal Process;~~

~~ii. Review of the operations; and~~

~~iii. Review of any emerging patterns of Grievance or Appeal in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.~~

~~7.~~8. Notices, Records, and Reports

a. Notice of Grievance or Appeal Procedures

i. Upon enrollment, and annually thereafter, the Health Network shall inform a Member, in writing, of the locations for filing a Grievance or Appeal, telephone numbers where a Complaint may be submitted, and related procedures regarding the Member Grievance or Appeal Process.

ii. The Health Network shall provide these notices in each of the Threshold Languages, as required by CalOptima.

b. Notice of Resolution for Grievances and Appeals shall be in a format and language that, at a minimum, meets applicable standards set forth in Title 42 Code of Federal Regulations section 438.10 and DHCS All Plan Letter (APL) 21-004: Standards for Determining Threshold Language, Nondiscrimination Requirements, and Language Assistance Services.

~~b.~~c. Records

i. The Health Network shall maintain written records of each Grievance or Appeal, including at least the following information:

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a) Date of receipt;

b) Member's name;

c) Nature of the Grievance or Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations as well as;

(i) Untimely assignments to providers;

(ii) Issues related to cultural and linguistic sensitivity;

(iii) Difficulty accessing specialists; and

(iv) Grievances related to out-of-network requests.

d) Names of Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the Grievance or Appeal; and

e) Disposition.

ii. The Health Network shall ~~maintain the~~accurately maintain and make accessible to DHCS, and, upon request, have available for the Centers for Medicare & Medicaid Services (CMS), written records of each Grievance or Appeal, including the date of receipt, Member's name, description of the problem, names of the Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

~~e.~~d. The Health Network shall continually evaluate and analyze Grievance data to identify systemic patters of improper services denials and other trends impacting health care delivery to Members assigned to the Health Network.

~~d.~~e. Reporting Requirements

i. The Health Network shall send to CalOptima GARS annually or as often as necessary for ongoing monitoring:

a) A copy of the Grievance or Appeal, and

b) A copy of the Acknowledgement Letter, Grievance Resolution Letter, Notice of Appeal Resolution Letter, and all supporting documentation that was used in investigation of the Grievance or Appeal upon request by CalOptima.

ii. The Health Network shall submit complete, accurate, reasonable, and timely aggregate and detailed Grievance or Appeal data, in the format required by CalOptima to CalOptima's GARS Department on a quarterly basis, in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting ~~(Attachments A and B).~~ .

~~C.~~B. If CalOptima determines that a Health Network has failed to comply with the requirements of this policy, CalOptima may take appropriate action including, but not limited to, taking steps to resolve a Member's Grievance or Appeal, implementing a decision, de-delegation of ~~or~~ Grievance

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and Appeal management for its assigned Members, or imposing corrective action or sanctions against the Health Network, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

~~A. Acknowledgment Letter~~
~~B. Grievance Resolution Letter~~
~~C. Notice of Appeal Resolution (Uphold)~~
~~D. Notice of Appeal Resolution (Overturn)~~

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
~~C.~~D. CalOptima Policy GG.1510: Appeal Process
E. CalOptima Policy HH.1104: Complaints of Discrimination
~~D.~~F. CalOptima Policy HH.1108: State Hearing Process and Procedures
~~E.~~G. CalOptima Policy HH.2002Δ: Sanctions
~~F.~~H. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
~~G.~~I. CalOptima Policy HH.2005Δ: Corrective Action Plan
~~H.~~J. CalOptima Policy HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
~~I.~~K. Department of Health Care Services All Plan Letter ~~17-006: Grievance~~(APL) 20-015: State Non-Discrimination and ~~Appeal~~Language Assistance Requirements ~~and Revised Notice Templates and "Your Rights" Attachments~~
~~J.~~L. Department of Health Care Services All Plan Letter (APL) 20-020: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
L. Department of Health Care Services All Plan Letter (APL) 20-022: COVID-19 Vaccine Administration
M. Department of Health Care Services All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
M. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
~~M.~~N. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
~~N.~~O. Title 22, California Code of Regulations (C.C.R.), §53858
~~O.~~P. Title 42, Code of Federal Regulations (C.F.R.), §§438.10, 438.3(u), 438.406 (b)(3~~)~~), 438.416 and 438.420(a), (b), and (c)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

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Date	Meeting
03/07/2019	Regular 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	06/01/1996	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/01/2000	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/01/2001	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	04/01/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	03/01/2014	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1103	CalOptima Health Network Member Complaint & Appeal	Medi-Cal
Revised	03/07/2019	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal
Revised	04/~~01~~01/2021	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal
Revised	TBD	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	~~Denial,~~Any of the following actions taken by CalOptima or a Health Network: 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 ~~requested~~previously authorized service~~, including~~. 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 ~~a decision~~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. 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.
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~~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).
Authorized Representative	For the purpose of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an appeal or grievance.
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance or Appeal.
~~Grievance and Appeals Process~~	~~The Process by which CalOptima and its Health Networks address and provide resolution to all Grievances and Appeals.~~
~~Grievance Resolution Letter~~	~~A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.~~
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.

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Term	Definition
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.
Grievance and Appeals Process	The Process by which CalOptima and its Health Networks address and provide resolution to all Grievances and Appeals.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
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.
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.
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.
State Hearing	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.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Working Days	Shall mean state of California working day(s).

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Policy:	HH.1103
Title:	**Health Network Member Grievance and Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in the Health Network as delegated by CalOptima, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

II. POLICY

A. CalOptima may delegate Grievances and Appeals functions to a Health Network for Members enrolled in that Health Network.

B. If CalOptima authorizes a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network:

1. The Health Network shall establish and maintain a Grievance and Appeals Process pursuant to which a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution.

2. The Grievances and Appeals Process shall address the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters.

3. The Health Network shall ensure prompt review and investigation of Member Grievances or Appeals by the appropriate department and/or staff delegated the responsibility to handle the Health Network's internal Grievance and Appeals operations.

4. The Health Network shall ensure that every Grievance submitted by a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, is reported to an appropriate level within the Health Network (i.e., quality of care versus quality of service).

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a. The Health Network shall immediately refer all medical quality of care issues to the Health Network's Medical Director or Designee for review.

5. The Health Network shall not discriminate or retaliate against any Member, a Member's Authorized Representative, or a provider on grounds that he or she filed a Grievance or Appeal as required by federal and State nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

6. The Health Network shall forward Grievances alleging discrimination to CalOptima Grievances and Appeals Resolution Services for timely submission to the Department of Health Care Services (DHCS) Office of Civil Rights (OCR) pursuant to CalOptima Policy HH.1104: Complaints of Discrimination.

C. The Health Network shall inform a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, of his or her right to file a Grievance at any time regarding an incident or issue that caused the Member's dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) through CalOptima or the Health Network, in accordance with the provisions of this policy.

D. The Health Network shall inform a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, during the Appeal Process, of his or her right to request a State Hearing after the Appeal Process has been exhausted or if the Health Network fails to send a resolution notice with thirty (30) calendar days of the Appeal being filed with the Health Network (deemed exhaustion), and of his or her right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearing Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. The Health Network shall allow a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, to file a Grievance when he or she disagrees with a decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

F. The Health Network shall process Grievances and Appeals for pharmacy services rendered or requested before implementation of Medi-Cal Rx, in accordance with Section III.A.5. of this Policy.

III. PROCEDURE

A. A Health Network delegated Grievances and Appeals functions for Members enrolled in that Health Network pursuant to Section II.B. of this Policy, shall maintain a Grievance and Appeal Process as follows:

1. Filing a Grievance or Appeal

a. A Member or a Member's Authorized Representative may file a Grievance or Appeal with the Member's Health Network, orally and/or in writing by telephone, in person, or facsimile.

b. A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The Health Network shall grant the Member continuation of the benefit until an Appeal decision is reached.

c. The Health Network shall ensure that its Members are informed of their right to Appeal a Health Network Utilization Management (UM) decision by filing a UM Appeal with the Health Network within sixty (60) calendar days of the date of the Notice of Adverse Benefit

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Determination (NABD)/Notice of Action (NOA) that denied, delayed, or modified a request for services.

d. In the event that a Health Network fails to issue a NABD/NOA within the required time frame, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination such that the Member has the right to request an Appeal.

e. The Health Network shall inform a Member of his or her right to file a Grievance with CalOptima, the Health Network, or the Secretary of Health and Human Services regarding violations of the Member's privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

f. Assistance to Members

i. The Health Network shall make the complaint forms and procedures for filing a Grievance or Appeal available to facilities that provide services to Members.

ii. The Health Network shall promptly provide the complaint forms and procedures to a Member upon request.

iii. The Health Network Member Services staff shall assist a Member with respect to the filing of a Grievance or Appeal.

iv. The Health Network shall provide assistance to a Member requiring assistance with filing a Grievance or Appeal and other procedural steps, including, but not limited to, a Member with limited English Proficiency LEP, disabilities, or cultural needs as provided for in Section III.A.6.a. of this Policy.

2. Acknowledgment of a Grievance or Appeal

a. Except as otherwise provided in Section III.A.4 of this policy, a Health Network shall send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance or Appeal indicating receipt of the Grievance or Appeal, the date of receipt of the Grievance or Appeal, the name, telephone number and address of the of the Grievance Resolution staff person whom the Member may contact regarding the Grievance or Appeal and the estimated completion date of resolution.

b. In instances of an oral Appeal request (excluding expedited Appeals) made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.

i. The date of the oral Appeal establishes the filing date for the Appeal.

ii. The Health Network will Process the Appeal whether or not a signed written Appeal confirmation is received from the Member Appeal.

c. A written confirmation does not apply to an oral grievance request.

d. If CalOptima receives a Member's Grievance or Appeal for a Health Network delegated Grievance and Appeals responsibilities, CalOptima shall forward the Grievance or Appeal immediately to the Health Network Member Grievance and Appeal staff for investigation and resolution.

3. Investigation and Resolution of a Grievance or Appeal

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a. The Health Network Member Grievance and Appeal staff shall promptly consult with the Health Network department responsible for the services or operations that are the subject of the Grievance or Appeal.

b. The Health Network shall ensure that the person making the final decision for the proposed resolution of a Grievance or Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

   i. An Appeal of a denial based on lack of Medical Necessity or that the service is experimental/investigational;

   ii. A Grievance regarding denial of an expedited resolution of an Appeal; and

   iii. Any Grievance or Appeal involving clinical issues.

c. The Health Network shall give a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Grievance or Appeal, evidence, testimony, facts and law in support of his or her Grievance or Appeal. CalOptima and the Health Network shall inform a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances and Appeals.

d. The Health Network shall take into account all comments, documents, records, and other information submitted by the Member or the Member's Authorized Representative, regardless of whether such information was submitted or considered during the initial review.

e. The Health Network shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by a Member, or a provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, at no cost.

f. The Health Network shall ensure timely written acknowledgement for each Grievance and request for an Appeal by sending the Member a Grievance Resolution Letter or Notice of Appeal Resolution as quickly as the Member's health condition requires, but not later than thirty (30) calendar days after receipt of an oral or written Grievance or Appeal, except as otherwise provided in Section III.A.4. of this Policy.

g. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

   i. Summary of the Member's Grievance;

   ii. The investigation made in the review process, including any referrals to the Quality Improvement Department for a quality of care review;

   iii. When possible, the outcome of the review;

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iv. Alternative resources or references, when applicable;

h. The Notice of Appeal Resolution shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. The results of the resolution and the date it was completed;

ii. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

iii. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

iv. Alternative resources or references, when applicable;

v. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made;

vi. The DHCS-approved "Your Rights" attachment; and

vii. Language assistance taglines and a nondiscrimination notice meeting the minimum requirements of DHCS All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements.

i. The Health Network shall translate the Grievance Resolution Letter or Notice of Appeal Resolution into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter or Notice of Appeal Resolution for all other languages upon request.

j. The Health Network shall take action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

4. Expedited UM Appeal or Grievances

a. If the Health Network receives a Grievance or Appeal that involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function, it shall Process such Grievance or Appeals an Expedited UM Appeal or Grievance:

i. Upon receipt of the expedited review Appeal or Grievance information, the Health Network Chief Medical Officer (CMO), or his or her Designee, shall conduct a medical review.

ii. The Health Network shall utilize specialist consultants, as appropriate.

iii. The Health Network shall notify the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

iv. The Health Network shall make a decision on the Expedited UM Appeal or Grievance request as quickly as the medical condition requires, but no later than seventy-two (72)

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hours after the Expedited UM Appeal or Grievance request is made to the Health Network. The Health Network shall provide verbal notice of the resolution of the expedited review to the Member.

v. The Health Network shall notify the Member, the Member's Authorized Representative, or provider that made the request on behalf of the CalOptima Member of the Expedited UM Appeal or Grievance decision through oral notice or in writing within seventy-two (72) hours after receiving the Expedited UM Appeal or Grievance. The Health Network shall provide a written notice within one (1) business day after an oral notice.

b. The Health Network shall take immediate action to implement the decision, in accordance with the Expedited UM Appeal or Grievance decision.

c. If the Health Network denies a request for an expedited Resolution of an Appeal, the Health Network must process the request for an Appeal in accordance with the standard Appeal process timeframes as required in this Policy.

5. Grievances for Pharmacy Services

a. For Grievances received by the Health Network for pharmacy services rendered upon the implementation of Medi-Cal Rx, the Health Network shall refer such Grievances received in writing to the Medi-Cal Rx Customer Service Center within three (3) calendar days pursuant to the Medi-Cal Rx transition requirements. For Grievances received via telephone, the Health Network shall refer the caller to the Medi-Rx Customer Service Center (CSC) telephone line pursuant to the Medi-Cal Rx transition requirements.

b. The Health Network shall categorize and track Grievances received for pharmacy services rendered upon the implementation of Medi-Cal Rx, including those calls that are referred to, or transferred directly to, Medi-Cal Rx for at least sixty (60) calendar days as required by DHCS.

6. In addition to any rights set forth in this Policy, a Member shall also have the right to:

a. Request the Health Network to provide assistance when completing Grievance and Appeal forms and other procedural steps, which includes, but is not limited to, providing all documents relied on for the Health Network's decision to the Member, and providing interpreter services or auxiliary aide(s) and a toll-free number with TTY/TDD and interpreter capability for assistance in the Grievance or Appeal process, or to provide translation of Grievance or Appeal correspondence..

b. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures, and applicable laws.

i. The Health Network shall notify a Member of this right annually, and in every Acknowledgement and Resolution Letter.

ii. A Member may request a State Hearing within one hundred and twenty (120) calendar days after the Notice of Appeal Resolution (NAR).

iii. To request a State Hearing, a Member may:

a) By Mail to:

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California Department of Social Services
State Hearings Division
P. O. Box 944243, M.S. 19-37
Sacramento, CA 95814;

b) By Calling: 1-800-743-8525, or for TDD only, 1-800-952-8349;

c) By Fax to: 1-916-309-3487; or

d) Online at www.cdss.ca.gov

c. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.

d. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal Process and may initiate a State Hearing.

e. Upon notice from CalOptima that a Member filed for a State Hearing, a Health Network shall grant Aid Paid Pending, if applicable, until the State Hearing occurs, or a decision is rendered, in accordance with CalOptima Policies HH.1108: State Hearing Process and Procedures and GG.1510: Appeal Process.

7. Responsible Staff

a. The Health Network shall designate an individual with authority to require corrective actions to be responsible for receiving Grievance or Appeal, issuing Grievance or Appeal decisions, and reporting to CalOptima.

b. The CalOptima Director of GARS or Designee shall have primary responsibility for the oversight of the Health Network Grievance and Appeal Process, including referring any non-compliance to the CalOptima Compliance Department for review and action, if needed.

8. Notices, Records, and Reports

a. Notice of Grievance or Appeal Procedures

i. Upon enrollment, and annually thereafter, the Health Network shall inform a Member, in writing, of the locations for filing a Grievance or Appeal, telephone numbers where a Complaint may be submitted, and related procedures regarding the Member Grievance or Appeal Process.

ii. The Health Network shall provide these notices in each of the Threshold Languages, as required by CalOptima.

b. Notice of Resolution for Grievances and Appeals shall be in a format and language that, at a minimum, meets applicable standards set forth in Title 42 Code of Federal Regulations section 438.10 and DHCS All Plan Letter (APL) 21-004: Standards for Determining Threshold Language, Nondiscrimination Requirements, and Language Assistance Services.

c. Records

i. The Health Network shall maintain written records of each Grievance or Appeal, including at least the following information:

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a) Date of receipt;

b) Member's name;

c) Nature of the Grievance or Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations as well as;

(i) Untimely assignments to providers;

(ii) Issues related to cultural and linguistic sensitivity;

(iii) Difficulty accessing specialists; and

(iv) Grievances related to out-of-network requests.

d) Names of Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the Grievance or Appeal; and

e) Disposition.

ii. The Health Network shall accurately maintain and make accessible to DHCS, and, upon request, have available for the Centers for Medicare & Medicaid Services (CMS), written records of each Grievance or Appeal, including the date of receipt, Member's name, description of the problem, names of the Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

d. The Health Network shall continually evaluate and analyze Grievance data to identify systemic patters of improper services denials and other trends impacting health care delivery to Members assigned to the Health Network.

e. Reporting Requirements

i. The Health Network shall send to CalOptima GARS annually or as often as necessary for ongoing monitoring:

a) A copy of the Grievance or Appeal, and

b) A copy of the Acknowledgement Letter, Grievance Resolution Letter, Notice of Appeal Resolution Letter, and all supporting documentation that was used in investigation of the Grievance or Appeal upon request by CalOptima.

ii. The Health Network shall submit complete, accurate, reasonable, and timely aggregate and detailed Grievance or Appeal data, in the format required by CalOptima to CalOptima's GARS Department on a quarterly basis, in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

B. If CalOptima determines that a Health Network has failed to comply with the requirements of this policy, CalOptima may take appropriate action including, but not limited to, taking steps to resolve a Member's Grievance or Appeal, implementing a decision, de-delegation of Grievance and Appeal

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management for its assigned Members, or imposing corrective action or sanctions against the Health Network, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Policy GG.1510: Appeal Process
E. CalOptima Policy HH.1104: Complaints of Discrimination
F. CalOptima Policy HH.1108: State Hearing Process and Procedures
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
I. CalOptima Policy HH.2005Δ: Corrective Action Plan
J. CalOptima Policy HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
K. Department of Health Care Services All Plan Letter (APL) 20-015: State Non-Discrimination and Language Assistance Requirements
L. Department of Health Care Services All Plan Letter (APL) 20-020: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx
L. Department of Health Care Services All Plan Letter (APL) 20-022: COVID-19 Vaccine Administration
M. Department of Health Care Services All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
M. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
N. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
O. Title 22, California Code of Regulations (C.C.R.), §53858
P. Title 42, Code of Federal Regulations (C.F.R.), §§438.10, 438.3(u), 438.406 (b)(3), 438.416 and 438.420(a), (b), and (c)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1996	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/01/2000	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/01/2001	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	04/01/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	03/01/2014	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1103	CalOptima Health Network Member Complaint & Appeal	Medi-Cal
Revised	03/07/2019	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal
Revised	04/01/2021	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal
Revised	TBD	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal

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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.
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.
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.
State Hearing	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.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Working Days	Shall mean state of California working day(s).

1

For 20220505 BOD Review Only

<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear <Member Name>:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or phone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date we received it.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call <SPECIALIST NAME>, Resolution Specialist at <**PHONE NUMBER**>. You may also examine the papers related to your [grievance or appeal] before and during the [grievance or appeal] process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima Customer Service at **1-714-246-8500**, or toll-free at **1-888-587-8088** (TTY **711**), Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. You can also visit our website at **www.caloptima.org**.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

Enclosures:
Notice of Nondiscrimination
Language Assistance Taglines

For 20220505 BOD Review for Retirement

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Toll-free Customer Service: 888-587-8088 | Customer Service: 714-246-8500
Main: 714-246-8400 | Fax: 714-246-8580 | TTY: 711

Back To Item Back to Agenda

<DATE>

<FIRST AND LAST NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <Member Name>:

This letter is in response to your complaint filed on <insert the date filed> about <insert the member's issue(s) or concern(s)>. Thank you for taking the time to share your concerns with us. We are sorry for any trouble this may have caused you.

In your complaint, you stated <insert the member's statement>.

<STANDARD GRIEVANCE> Our Grievance and Appeals Resolution Services department reviewed your complaint <summary of your investigation, outcomes, referrals, alternative resources or references when applicable including name(s) of person(s) contacted, department, medical group & any outcomes that are relevant to member not subject to peer review protection>.

<QUALITY OF CARE INSERT:> I have also referred your concerns to CalOptima's Quality Improvement (QI) department to review the health care you received. The reason for this review is to decide if the health care provided meets the professional standards in the community. You will receive an acknowledgment letter from our QI department explaining the review process. The review process normally takes 120 days to complete. If the standards have been met, no further action is needed. If not, CalOptima will take the correct action necessary. California law does not let us share the details of this review.

CalOptima will take all required actions to solve your concerns. All concerns by our members, including those that could be related to quality of care, fraud and abuse, quality of service or access to care problems are taken very seriously. We monitor these issues to look for ways to improve our programs and prevent future problems. It is our goal to provide access to quality care and services to our members.

Your input is important to us, and we are here to help you with your health care needs. If you have questions or concerns about this letter, please call me at **<X-XXX-XXX-XXXX>**.

For future assistance or questions about your benefits, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088** (TTY **711**), Monday through

505 City Parkway West | Orange, CA 92868 | www.caloptima.org

Main: 714-246-8400 | Fax: 714-246-8492 | TDD/TTY: 711

For 20220505 BOD Review for Retirement

Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. You can also visit our website at **www.caloptima.org**.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

Enclosures:
Notice of Nondiscrimination
Language Assistance Taglines

For 20220505 BOD Review for Retirement

Medi-Cal CalOptima A Public Agency Better. Together.

"Uphold"

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

Identification Number: [Identification Number]

RE: [Service requested]

You [Or Name of requesting provider or authorized representative on your behalf] appealed the [denial, delay, modification, or termination] of [Service requested] on [Date appeal received].

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on [date] and has decided to uphold the decision. This request is still denied. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

On [Date] at [Time], you were contacted and informed of the decision; OR a message was left informing you of the decision; OR a message was left asking for a call back].

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call [Grievance Resolution Staff Name] at [Phone number].

If you need help reading this letter or have any questions, please call [Grievance Resolution Staff Name] at [Phone number].

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**. You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged

[Case #]

MCAL MM-17-37_DHCS Approved 04.07.2020_NAR Uphold (GARS)(COVID-19)

For 20220505 BOD Review for Retirement

to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

During the coronavirus (COVID-19) public health emergency, you have an additional 120 days over and above the initial 120 days allowed to request a State Hearing. This gives you 240 days from the date of this Notice of Appeal Resolution to request a State Hearing.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

[Grievance Resolution Staff Name], [Title]
Grievance and Appeals

Enclosed: Your Rights under Medi-Cal Managed Care
Notice of Non-Discrimination
Language Assistance Taglines

For 20220505 BOD Review for Retirement

"Overturn"

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Identification Number]

RE: [Service requested]

You [Or Name of requesting provider or authorized representative on your behalf] appealed the [denial, delay, modification, or termination] of [Service requested] on [Date Appeal Received].

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on [date] and has decided to overturn the original decision. This request is now approved. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision].

CalOptima has 72 hours to approve or provide you the service.

Your request has been approved under authorization number [#] from [date] to [date] with [provider] OR payment has been made. On [Date] at [Time], you were contacted and informed of the decision; OR a message was left informing you of the decision; OR a message was left asking for a call back].

If you need help reading this letter or have any questions, please call [Specialist Name], Resolution Specialist at [Phone number].

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at **1-888-587-8088.**

[Case #]

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Main: 714-246-8400 | Fax: 714-246-8580 | TDD/TTY: 800-735-2929

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For 20220505 BOD Review for Retirement

This notice does not affect any of your other Medi-Cal services.

Sincerely,

[Specialist Name], Resolution Specialist
Grievance and Appeals

For 20220505 BOD Review for Retirement

Policy:	HH.1109
Title:	**Complaints Decision Matrix**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	
Effective Date:	01/01/2001
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy defines the process and structure for identifying and referring all Member and Provider Complaints that requires administrative approval for resolution by CalOptima.

II. POLICY

A. All Member and Provider Complaints, that are the adjudication responsibility of CalOptima's Grievance and Appeals Resolution Services (GARS), shall be escalated for resolution approval to the appropriate authority, as defined by this Policy and CalOptima's Complaint Decision Matrix.

B. All quality of care issues identified through the Complaint Process shall be referred to CalOptima's Quality Improvement (QI) Department for review~~.~~, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

C. All Complaints involving denials for Medical Necessity shall be referred to CalOptima's Chief Medical Officer (CMO~~),~~) or their Designee~~,~~ for review.~~ CalOptima shall utilize board-certified physicians from appropriate specialty areas, as determined by the CMO~~,~~ or their Designee~~,~~ to assist in making determinations of Medical Necessity.

D. Providers must first complete the CalOptima Utilization Management (UM) appeal process, pharmacy UM appeal process, long-term care level of care process, or the CalOptima Provider Dispute Resolution process prior to filing a Complaint with CalOptima, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint, and MA.9006: Provider Complaint Process.

E. Complaints that are the adjudication and resolution responsibility of a Health Network shall be processed by the Health Network, in accordance with CalOptima Policies HH.1103: Health Network Member Grievance and Appeal Process, HH.1101: CalOptima Provider Complaint, and MA.9006: Provider Complaint Process and are not subject to referral for resolution approval, as defined by CalOptima's Complaint Decision Matrix.

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F. Complaints involving alleged acts of discrimination shall be processed as required by federal and State nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

III. PROCEDURE

A. The CalOptima GARS staff shall review, process, investigate, and make decision recommendations regarding the resolution of Member and Provider Complaints.

B. All Complaints related to access to services, quality of care, or quality of service that impacts the Member's ability to obtain care and resulted in a complication shall be referred to CalOptima's QI Department for review, trending, and any action deemed necessary based on the review.

C. CalOptima shall approve Complaint decisions, in accordance with the Complaint Decision Matrix.

D. The CalOptima GARS Director, or their Designee, shall determine when a Complaint decision requires escalation for administrative approval.

E. The CalOptima GARS staff shall prepare the Complaint case for review by the appropriate level of decision-maker, including the referral of all clinical cases for review by the CMO, or their Designee.

F. The CalOptima GARS staff shall record the Complaint decision in the electronic Complaint file and complete the Complaint Process, in accordance with CalOptima Policies HH.1102: Member Grievance, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, MA.9001: Member Complaint Process, MA.9002: Member Grievance Process, HH.1101: CalOptima Provider Complaint, and MA.9006: Provider Complaint Process.

IV. ATTACHMENT(S)

A. Complaint Decision Matrix

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~D.~~E. CalOptima Policy CMC.9001: Member Complaint Process
~~E.~~F. CalOptima Policy CMC.9002: Member Grievance Process
~~F.~~G. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~G.~~H. CalOptima Policy HH.1102: Member Grievance
~~H.~~I. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
J. CalOptima Policy HH.1104: Complaints of Discrimination
K. CalOptima Policy GG.1611: Potential Quality Issue Review Process
~~I.~~L. CalOptima Policy MA.9001: Complaint Process
~~J.~~M. CalOptima Policy MA.9002: Member Grievance Process
~~K.~~N. CalOptima Policy MA.9006: Provider Complaint Process

For 20220505 BOD Review Only

~~L.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~

~~M.~~O. Department of Health Care Services All Plan Letter ~~17-006~~(APL) 21-011: Grievance and ~~Appeal~~Appeals Requirements ~~and Revised,~~ Notice ~~Templates~~ and "Your Rights" ~~Attachments~~Templates

~~N.~~P. CalOptima Utilization Management Program

Q. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
10/21/2009	Department of Health Care Services (DHCS)	Approved as Submitted
06/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

~~None to Date~~

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2001	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	11/01/2004	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	01/01/2009	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	01/01/2013	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	03/01/2014	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	05/01/2015	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	06/01/2016	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	07/01/2017	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	TBD	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect

For 20220506 BOD Review Only

IX. GLOSSARY

Term	Definitions
Complaint	Medi-Cal: ~~An oral or written expression indicating dissatisfaction with any aspect of~~A complaint is the same as a Grievance. If CalOptima ~~program, other than~~is unable to distinguish between a Grievance and an ~~Adverse Benefit Determination~~Inquiry, it must be considered a Grievance. OneCare~~/OneCare Connect~~: Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. ~~A Complaint may include concerns about the operations of Providers or CalOptima such as waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered.~~ A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
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.

For 20220505 BOD Review Only

Term	Definitions
Medically Necessary or Medical Necessity	~~Necessary services~~ Medi-Cal: 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~~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: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. 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~~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~~medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Practitioner	A licensed independent ~~Practitioner~~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), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services~~.~~..

For 20220505 BOD Review Only

Term	Definitions
Provider	Medi-Cal: 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. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse ~~Practitioner~~practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, ~~Physician Medical Group~~physician group, or other person or institution who furnishes Covered Services.

For 20220505 BOD Review Only

Policy:	HH.1109
Title:	**Complaints Decision Matrix**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable

CEO Approval:

Effective Date:	01/01/2001
Revised Date:	TBD

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative

For 20220505 ROD Review Only

I. PURPOSE

This policy defines the process and structure for identifying and referring all Member and Provider Complaints that requires administrative approval for resolution by CalOptima.

II. POLICY

A. All Member and Provider Complaints, that are the adjudication responsibility of CalOptima's Grievance and Appeals Resolution Services (GARS), shall be escalated for resolution approval to the appropriate authority, as defined by this Policy and CalOptima's Complaint Decision Matrix.

B. All quality of care issues identified through the Complaint Process shall be referred to CalOptima's Quality Improvement (QI) Department for review, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

C. All Complaints involving denials for Medical Necessity shall be referred to CalOptima's Chief Medical Officer (CMO) or their Designee for review. CalOptima shall utilize board-certified physicians from appropriate specialty areas, as determined by the CMO or their Designee to assist in making determinations of Medical Necessity.

D. Providers must first complete the CalOptima Utilization Management (UM) appeal process, pharmacy UM appeal process, long-term care level of care process, or the CalOptima Provider Dispute Resolution process prior to filing a Complaint with CalOptima, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint, and MA.9006: Provider Complaint Process.

E. Complaints that are the adjudication and resolution responsibility of a Health Network shall be processed by the Health Network, in accordance with CalOptima Policies HH.1103: Health Network Member Grievance and Appeal Process, HH.1101: CalOptima Provider Complaint, and MA.9006: Provider Complaint Process and are not subject to referral for resolution approval, as defined by CalOptima's Complaint Decision Matrix.

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F. Complaints involving alleged acts of discrimination shall be processed as required by federal and State nondiscrimination law and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

III. PROCEDURE

A. The CalOptima GARS staff shall review, process, investigate, and make decision recommendations regarding the resolution of Member and Provider Complaints.

B. All Complaints related to access to services, quality of care, or quality of service that impacts the Member's ability to obtain care and resulted in a complication shall be referred to CalOptima's QI Department for review, trending, and any action deemed necessary based on the review.

C. CalOptima shall approve Complaint decisions, in accordance with the Complaint Decision Matrix.

D. The CalOptima GARS Director, or their Designee, shall determine when a Complaint decision requires escalation for administrative approval.

E. The CalOptima GARS staff shall prepare the Complaint case for review by the appropriate level of decision-maker, including the referral of all clinical cases for review by the CMO, or their Designee.

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IV. ATTACHMENT(S)

A. Complaint Decision Matrix

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima Policy CMC.9001: Member Complaint Process
F. CalOptima Policy CMC.9002: Member Grievance Process
G. CalOptima Policy HH.1101: CalOptima Provider Complaint
H. CalOptima Policy HH.1102: Member Grievance
I. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
J. CalOptima Policy HH.1104: Complaints of Discrimination
K. CalOptima Policy GG.1611: Potential Quality Issue Review Process
L. CalOptima Policy MA.9001: Complaint Process
M. CalOptima Policy MA.9002: Member Grievance Process
N. CalOptima Policy MA.9006: Provider Complaint Process

For 20220505 BOD Review Only

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O. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates
P. CalOptima Utilization Management Program
Q. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
10/21/2009	Department of Health Care Services (DHCS)	Approved as Submitted
06/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2001	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	11/01/2004	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	01/01/2009	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	01/01/2013	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	03/01/2014	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	05/01/2015	HH.1109	Complaints Decision Matrix	Medi-Cal
Revised	06/01/2016	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	07/01/2017	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect
Revised	TBD	HH.1109	Complaints Decision Matrix	Medi-Cal OneCare OneCare Connect

For 20220505 BOD Review Only

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IX. GLOSSARY

Term	Definitions
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
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.

For 20220505 BOD Review Only

Term	Definitions
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: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. 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.
Member	A beneficiary enrolled in a CalOptima program.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services..

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Term	Definitions
Provider	Medi-Cal: 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. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.

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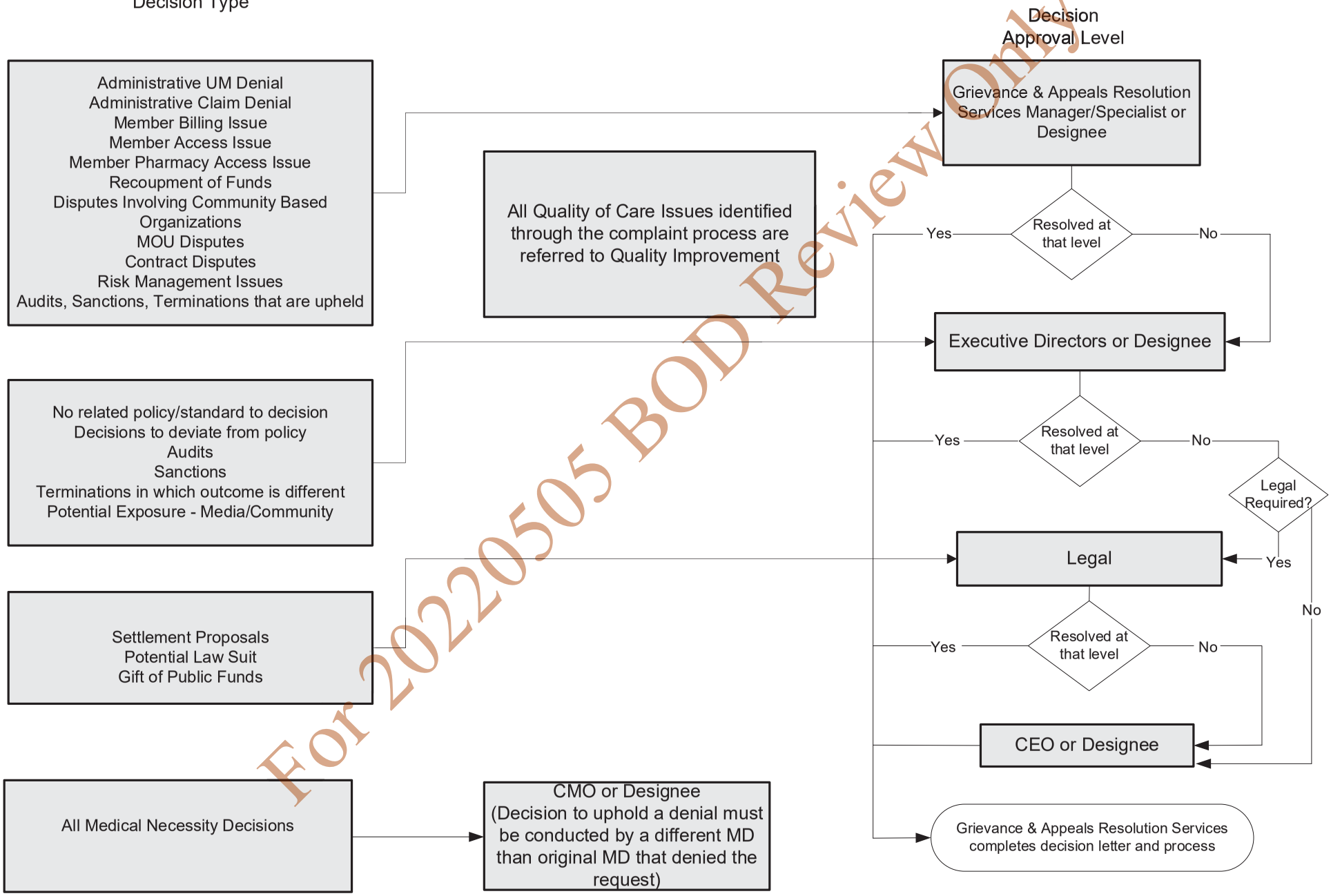
Grievance & Appeals Resolution Services
Complaint Decision Matrix

All complaints are received, processed and investigated by Grievance Resolution Specialists.
Resolution Decisions are referred and escalated as follows:



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Policy:	HH.1104
Title:	**Complaints of Discrimination**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	04/01/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

To ensure that CalOptima, Health Networks, Providers, and Practitioners do not discriminate against Members in the provision of Covered Services, and that appropriate actions are taken to handle and report Complaints of discrimination in a timely manner.

II. POLICY

A. CalOptima, a Health Network, Providers, and Practitioners shall comply with all applicable federal and state nondiscrimination requirements including, but not limited to:

1. All applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; The Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; federal implementing regulations issued under the above-listed statutes; and all other laws regarding nondiscrimination.

2. California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Government Code sections 7405 and 11135, Welfare & Institutions Code section 14029.91, and state implementing regulations.

~~A.~~B. CalOptima, a Health Network, Provider, or Practitioner shall not discriminate against a Member ~~because of~~based on the following characteristics protected by federal and state nondiscrimination laws:

1. Sex;

~~1.~~2. Race;

~~2.~~3. Color;

~~3.1. Creed;~~

4. Religion;

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5. Ancestry;

6. National origin;

7. Creed;

8. Ethnic group identification;

9. Age;

10. Physical or mental disability;

11. Medical condition;

12. Genetic information;

~~6.~~13. Marital status;

14. Gender;

15. Gender identity;

16. Health status;

~~7.~~17. Sexual orientation;

~~8.~~1. ~~National origin;~~

~~9. Age;~~

~~10. Sex;~~

~~11.~~18. Language;

~~12.~~1. ~~Gender identity;~~

~~13.~~1. Identification with any other persons or groups defined in Penal Code section 422.56;

~~14.~~19. ~~Physical~~ or ~~mental disability; or~~

~~15.~~20. Health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment.

~~B.~~C. Discrimination on the grounds included in Section II.~~A~~B. of this Policy, include but are not limited to:

1. Denying any Member any Covered Services or availability of a facility;

2. Providing to a Member any Covered Services which is different, or is provided in a different manner or at a different time from that provided to other Members except where medically indicated;

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

4. Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member different from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, ~~Membership~~membership or other requirement or condition which individuals must meet in order to be provided any Covered Service; ~~and~~

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

6. Failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability; and

7. Failing to ensure meaningful access to programs and activities for limited English proficient Members and potential enrollees.

D. For Grievances alleging discrimination, CalOptima shall designate a discrimination Grievance coordinator who is responsible for ensuring compliance with federal and State nondiscrimination requirements. CalOptima's discrimination Grievance coordinator must be available to:

1. Answer questions and provide appropriate assistance to CalOptima staff and Members regarding state and federal nondiscrimination legal obligations;

2. Advise CalOptima staff about nondiscrimination best practices and accommodating persons and disabilities;

3. Investigate Grievances alleging discrimination related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws; and

4. Investigate and process any Americans with Disabilities Act (ADA), Section 504, Section 1557, and/or Government Code section 11135 Grievances received by CalOptima.

E. CalOptima shall forward copies of all Medi-Cal Member and OneCare Connect Member (involving Medi-Cal based services) Grievances alleging discrimination on the basis of any characteristic protected by federal or state nondiscrimination law to the Department of Health Care Services (DHCS) in accordance with Section III.C. of this Policy.

~~C.~~F. All alleged acts of discrimination against any Member shall be treated as a Complaint~~,~~ and handled pursuant to CalOptima Policies HH.1102: Member Grievance, CMC.~~9001~~9002: Member ~~Complaint~~Grievance Process and MA.~~9001: Complaint~~9002: Member Grievance Process.

~~D.~~G. ~~A~~Except as provided in Section III.D. of this Policy, a Health Network shall report a Member Complaint ~~regarding~~alleging discrimination to the CalOptima Grievance and Appeals Resolution Services (GARS) Department on a concurrent basis.

~~E.~~H. CalOptima shall document all alleged acts of discrimination, and track and trend these occurrences.

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I. In addition to the reporting requirements outlined in Section III.C. of this Policy, CalOptima shall forward summaries of all ~~**Complaints of**~~Medi-Cal Member and OneCare Connect Member (involving Medi-Cal based services) Grievances alleging discrimination to DHCS on a monthly basis, via the DHCS Monthly Grievance Report for review.

J. CalOptima shall adopt procedures to ensure the prompt and equitable resolution of Grievances alleging discrimination by CalOptima. CalOptima shall not require a Member or potential enrollee to file a Grievance alleging discrimination with CalOptima before filing with the DHCS Office of Civil Rights (OCR) or the U.S. Health and Human Services (HHS) Office for Civil Rights (OCR).

K. CalOptima shall provide Nondiscrimination Notices in at least 12-point font that inform Members, potential enrollees, and the public about nondiscrimination, protected characteristics, and accessibility requirements in the Member Handbook/Evidence of Coverage, Member information, and all other information notices targeted to Members, potential enrollees and the public. In addition, CalOptima shall post the Nondiscrimination Notices in conspicuous physical locations where CalOptima interacts with the public, as well as on CalOptima's website in a location that allows any visitor to the website to easily locate information.

L. If CalOptima and/or one of its regulators determines that a person or entity has discriminated against a CalOptima Member and is not otherwise terminated from CalOptima or participation in its programs, CalOptima will require the specific person or entity to complete the non-discrimination portion of CalOptima's annual compliance training within sixty (60) calendar days of the final determination.

~~F.~~M. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, including language assistance taglines and a notice of non-discrimination in compliance with the requirements set forth by the Department of Health Care Services (DHCS~~) on a quarterly basis, via the DHCS Quarterly Complaint Report for review.~~), and in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

III. PROCEDURE

A. All Grievances alleging discrimination shall be forwarded to the discrimination Grievance coordinator to receive, investigate, respond and report to appropriate regulatory agency(ies), as applicable. When responding to Grievances alleging discrimination, CalOptima shall include the pre-approved nondiscrimination notices and language taglines that includes information about how to file a discrimination grievance directly with the Department of Health Care Services Office for Civil Rights or Department of Health and Human Services' Office for Civil Rights, as applicable.

~~A.~~B. On a ~~quarterly~~monthly basis, CalOptima's GARS Department shall prepare a DHCS ~~Quarterly Complaint~~Monthly Grievance Report for submission to the DHCS. The DHCS ~~Quarterly Complaint~~Monthly Grievance Report shall include any ~~**Complaints of**~~ Medi-Cal Member and OneCare Connect Member (involving Medi-Cal based services) Grievances alleging discrimination received during that ~~quarter~~month.

~~B.~~C. ~~CalOptima shall~~ Concurrent with or subsequent to the discrimination Grievance coordinator's investigation and review of the Grievances alleging discrimination, CalOptima's GARS Department shall forward any potential quality of care issues due to alleged discrimination to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO~~),~~) or their Designee~~,~~ and any action deemed necessary under the quality review process.

D. CalOptima shall forward detailed copies of all Medi-Cal Member and OneCare Connect Member (involving Medi-Cal based services) Grievances alleging discrimination on the basis of any

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characteristic protected by federal or state nondiscrimination law to DHCS OCR email DHCS.DiscriminationGrievances@dhcs.ca.gov, within ten (10) calendar days of mailing a discrimination Grievance resolution letter to a Member. CalOptima must submit the following information in a secure format:

1. The original Grievance alleging discrimination;

2. The Provider's or other accused party's response to the Grievance;

3. Contact information for the CalOptima personnel primarily responsible for investigating and responding to the Grievance;

4. Contact information for the Member filing the Grievance and for the Provider or other accused party that is the subject of the Grievance;

5. All correspondence with the Member regarding the Grievance, including, but not limited to, the Grievance acknowledgement letter and Grievance resolution letter(s) sent to the Member; and

6. The results of CalOptima's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

E. A Health Network delegated to handle Member Grievances alleging discrimination shall establish policies and procedures that, at a minimum, meet the requirements outlined in this Policy and shall forward to the CalOptima GARS Department the information described in Section III.C. of this Policy within five (5) calendar days of mailing a discrimination Grievance resolution letter to a Member.

IV. ATTACHMENT(S)

Not Applicable
~~A. Member Complaint Form (Medi-Cal)~~
~~B. Member Request Appeal or Complaint Form (H8016_GD1001)~~
~~C. Member Request Appeal or Complaint Form (H5433_08407)~~

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS)
C. CalOptima Policy CMC.9002: Member Grievance Process
D. CalOptima Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Policy HH.1102: Member Grievance
F. CalOptima Policy MA.9002: Member Grievance Process
~~C.~~G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~D.~~H. Department of Health Care Services All Plan Letter ~~17-011~~(APL) 21-004: Standards for Determining Threshold Languages ~~and~~, Nondiscrimination Requirements ~~for Section 1557 of the Affordable Care Act~~, and Language Assistance Services
I. Department of Health Care Services All Plan Letter (APL) 20-017: Requirements for Reporting Managed Care Program Data
~~E.~~J. CalOptima Policy CMC.9001: Member Complaint Process
~~F.~~K. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~ Grievance
~~G. CalOptima Policy MA.9001: Complaint Process~~
L. Unruh Civil Rights Act
M. Title VI of the Civil Rights Act of 1964

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N. Title IX of the Education Amendments of 1972
O. The Age Discrimination Act of 1975
P. Rehabilitation Act of 1973, as amended
Q. Americans with Disabilities Act of 1990, as amended
R. Section 1557 of the Patient Protection and Affordable Care Act
~~H.~~S. Title 42, United States Code (U.S.C.), §2000d
T. California Government Code §§7405 and 11135
~~I.~~U. California Penal Code ~~Section~~ §422.56
V. California Welfare & Institutions Code §14029.91

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
06/10/2015	Department of Health Care Services (DHCS)
12/13/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	07/01/1998	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	09/01/2000	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	01/01/2002	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	06/01/2007	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	01/01/2013	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	03/01/2014	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	05/01/2015	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	06/01/2016	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect
Revised	02/01/2018	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect
Revised	04/01/2022	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Complaint	Medi-Cal: ~~An oral or written expression indicating dissatisfaction with any aspect of~~A complaint is the same as a Grievance. If CalOptima ~~program.~~is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare~~/OneCare Connect~~: Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. ~~A Complaint may include concerns about the operations of Providers or CalOptima such as waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered.~~ A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
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 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and 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 not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. ~~OneCare/~~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 Contract with the Department of Health Care Services (DHCS) and Centers ~~of~~for Medicare & Medicaid Services (CMS~~) Contract.~~).

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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.
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.
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	A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMG)~~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	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Practitioner	A licensed independent ~~Practitioner~~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), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

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Term	Definition
Provider	Medi-Cal: 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. OneCare: A physician, pharmacist, nurse, nurse mid-wife, nurse ~~Practitioner~~practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, ~~Physician Medical Group~~or other person or institution who furnishes Covered Services. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.

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Policy:	HH.1104
Title:	**Complaints of Discrimination**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	
Effective Date:	06/01/1998
Revised Date:	04/01/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

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2. California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Government Code sections 7405 and 11135, Welfare & Institutions Code section 14029.91, and state implementing regulations.

B. CalOptima, a Health Network, Provider, or Practitioner shall not discriminate against a Member based on the following characteristics protected by federal and state nondiscrimination laws:

1. Sex;

2. Race;

3. Color;

4. Religion;

5. Ancestry;

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6. National origin;

7. Creed;

8. Ethnic group identification;

9. Age;

10. Physical or mental disability;

11. Medical condition;

12. Genetic information;

13. Marital status;

14. Gender;

15. Gender identity;

16. Health status;

17. Sexual orientation;

18. Language;

19. Identification with any other persons or groups defined in Penal Code section 422.56; or

20. Health status requirements or requirements for health care services during enrollment, re-enrollment, or disenrollment.

C. Discrimination on the grounds included in Section II.B. of this Policy, include but are not limited to:

1. Denying any Member any Covered Services or availability of a facility;

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

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6. Failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability; and

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3. Investigate Grievances alleging discrimination related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws; and

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F. All alleged acts of discrimination against any Member shall be treated as a Complaint and handled pursuant to CalOptima Policies HH.1102: Member Grievance, CMC.9002: Member Grievance Process and MA.9002: Member Grievance Process.

G. Except as provided in Section III.D. of this Policy, a Health Network shall report a Member Complaint alleging discrimination to the CalOptima Grievance and Appeals Resolution Services (GARS) Department on a concurrent basis.

H. CalOptima shall document all alleged acts of discrimination, and track and trend these occurrences.

I. In addition to the reporting requirements outlined in Section III.C. of this Policy, CalOptima shall forward summaries of all Medi-Cal Member and OneCare Connect Member (involving Medi-Cal based services) Grievances alleging discrimination to DHCS on a monthly basis, via the DHCS Monthly Grievance Report for review.

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where CalOptima interacts with the public, as well as on CalOptima's website in a location that allows any visitor to the website to easily locate information.

L. If CalOptima and/or one of its regulators determines that a person or entity has discriminated against a CalOptima Member and is not otherwise terminated from CalOptima or participation in its programs, CalOptima will require the specific person or entity to complete the non-discrimination portion of CalOptima's annual compliance training within sixty (60) calendar days of the final determination.

M. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, including language assistance taglines and a notice of non-discrimination in compliance with the requirements set forth by the Department of Health Care Services (DHCS), and in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

III. PROCEDURE

A. All Grievances alleging discrimination shall be forwarded to the discrimination Grievance coordinator to receive, investigate, respond and report to appropriate regulatory agency(ies), as applicable. When responding to Grievances alleging discrimination, CalOptima shall include the pre-approved nondiscrimination notices and language taglines that includes information about how to file a discrimination grievance directly with the Department of Health Care Services Office for Civil Rights or Department of Health and Human Services' Office for Civil Rights, as applicable.

B. On a monthly basis, CalOptima's GARS Department shall prepare a DHCS Monthly Grievance Report for submission to the DHCS. The DHCS Monthly Grievance Report shall include any Medi-Cal Member and OneCare Connect Member (involving Medi-Cal based services) Grievances alleging discrimination received during that month.

C. Concurrent with or subsequent to the discrimination Grievance coordinator's investigation and review of the Grievances alleging discrimination, CalOptima's GARS Department shall forward any potential quality of care issues due to alleged discrimination to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

D. CalOptima shall forward detailed copies of all Medi-Cal Member and OneCare Connect Member (involving Medi-Cal based services) Grievances alleging discrimination on the basis of any characteristic protected by federal or state nondiscrimination law to DHCS OCR email DHCS.DiscriminationGrievances@dhcs.ca.gov, within ten (10) calendar days of mailing a discrimination Grievance resolution letter to a Member. CalOptima must submit the following information in a secure format:

1. The original Grievance alleging discrimination;

2. The Provider's or other accused party's response to the Grievance;

3. Contact information for the CalOptima personnel primarily responsible for investigating and responding to the Grievance;

4. Contract information for the Member filing the Grievance and for the Provider or other accused party that is the subject of the Grievance;

5. All correspondence with the Member regarding the Grievance, including, but not limited to, the Grievance acknowledgement letter and Grievance resolution letter(s) sent to the Member; and

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6. The results of CalOptima's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

E. A Health Network delegated to handle Member Grievances alleging discrimination shall establish policies and procedures that, at a minimum, meet the requirements outlined in this Policy and shall forward to the CalOptima GARS Department the information described in Section III.C. of this Policy within five (5) calendar days of mailing a discrimination Grievance resolution letter to a Member.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Department of Health Care Services (DHCS)
C. CalOptima Policy CMC.9002: Member Grievance Process
D. CalOptima Policy DD.2002: Cultural and Linguistic Services
E. CalOptima Policy HH.1102: Member Grievance
F. CalOptima Policy MA.9002: Member Grievance Process
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Department of Health Care Services All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
I. Department of Health Care Services All Plan Letter (APL) 20-017: Requirements for Reporting Managed Care Program Data
J. CalOptima Policy CMC.9001: Member Complaint Process
K. CalOptima Policy HH.1102: Member Grievance
L. Unruh Civil Rights Act
M. Title VI of the Civil Rights Act of 1964
N. Title IX of the Education Amendments of 1972
O. The Age Discrimination Act of 1975
P. Rehabilitation Act of 1973, as amended
Q. Americans with Disabilities Act of 1990, as amended
R. Section 1557 of the Patient Protection and Affordable Care Act
S. Title 42, United States Code (U.S.C.), §2000d
T. California Government Code §§7405 and 11135
U. California Penal Code §422.56
V. California Welfare & Institutions Code §14029.91

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
06/10/2015	Department of Health Care Services (DHCS)
12/13/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

For 2022005 BOD Review for Ratification

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1998	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	07/01/1998	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	09/01/2000	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	01/01/2002	DD.1112	Complaints of Discrimination	Medi-Cal
Revised	06/01/2007	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	01/01/2013	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	03/01/2014	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	05/01/2015	HH.1104	Complaints of Discrimination	Medi-Cal
Revised	06/01/2016	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect
Revised	02/01/2018	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect
Revised	04/01/2022	HH.1104	Complaints of Discrimination	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
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 not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers 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 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
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.
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	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 beneficiary enrolled in a CalOptima program.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

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Term	Definition
Provider	Medi-Cal: 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. OneCare: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.

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Policy:	MA.9001
Title:	**Complaint Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
RETIREMENT:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the process by which CalOptima shall address and resolve a Complaint, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. Grievance and Appeals Resolution Services (GARS) staff shall be responsible for all Complaints that are the adjudication responsibility of CalOptima.

B. CalOptima shall process every Complaint as an Appeal, a Grievance, or both.

1. If a Complaint involves an adverse Organization Determination or dispute regarding cost-sharing amounts, CalOptima shall process such Complaint as an Appeal, in accordance with CalOptima Policies MA.9003: Standard Appeal, MA.9004: Expedited Appeal, or MA.9005: Payment Appeal.

2. If a Complaint involves any aspect of CalOptima other than an adverse Organization or Coverage Determination, or a dispute regarding cost-sharing amounts, CalOptima shall process such Complaint as a Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process.

3. If a Complaint involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

4. CalOptima shall ensure that there is no discrimination against a Member on the basis that such Member filed a Complaint, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

C. GARS staff shall classify a Complaint as a Grievance, Standard Appeal, Expedited Appeal, or Payment Appeal, and shall escalate it for resolution approval to the appropriate authority, in accordance with this policy and CalOptima Policies MA.9002: Member Grievance Process, MA.9003: Standard Appeal, MA.9004: Expedited Appeal, and MA.9005: Payment Appeal.

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D. If CalOptima determines that it misclassified a Member's Appeal as a Grievance, it shall notify the Member, in writing, of the misclassified Complaint, and shall process the reclassified Appeal through the Appeal process. CalOptima shall consider the date of receipt of the original Complaint as the date of receipt of the Appeal.

E. A Member, or a Member's Authorized Representative, may file a Complaint regarding quality of care to CalOptima, or to the Quality Improvement Organization (QIO).

1. CalOptima shall notify a Member of the Complaint process available to the Member through the QIO upon initial enrollment and annually thereafter.

2. If a Member files a Complaint regarding quality of care to the QIO, CalOptima shall cooperate with the QIO to resolve the Complaint.

3. If a Member files a Complaint regarding quality of care to CalOptima, CalOptima shall process such Complaint through the Grievance process, and make a referral to the Quality Improvement (QI) Department.

4. CalOptima shall respond to a Complaint related to quality of care, in writing, regardless of whether the Complaint is filed orally, or in writing. The written response shall include a description of the Member's right to file a written Complaint with the QIO.

F. CalOptima shall inform a Member, in writing, of the Complaint process, including telephone numbers and locations for filing a Complaint, and the difference between a Grievance and an Appeal.

G. CalOptima's timeframe for processing a Complaint through the Grievance or Appeal process shall begin upon receipt of the Complaint.

III. PROCEDURE

A. A Member, or a Member's Authorized Representative, may file a Complaint:

1. Verbally, by telephone, or in person with the Customer Service Department; or

2. In writing to GARS staff.

B. CalOptima shall resolve the Complaint as expeditiously as the Member's case requires, based on the Member's health status, but not later than thirty (30) calendar days upon receipt of the Complaint, unless a fourteen (14)-day extension has been granted.

C. If a Complaint involves CalOptima's refusal to grant a Member's request to expedite a Determination or Appeal, or to extend the decision-making timeframe, CalOptima shall respond to the Member within twenty-four (24) hours.

D. If a CalOptima employee receives a Member's verbal Complaint, he or she shall:

1. Document, in writing, the Member's name, telephone number, and a brief statement of the Complaint;

2. Repeat the Member's Complaint back to the Member for accuracy; and

3. Immediately refer the Complaint to GARS staff.

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E. Upon request from a Member, CalOptima shall mail a OneCare Member Request, Appeal, or Complaint Form to the Member.

F. CalOptima shall ensure that Members have equal access to, and can fully participate in, the Complaint process by providing assistance to Members with limited English proficiency, vision disorders, or other communicative impairments, as follows:

1. Translation of forms and responses;

2. Interpretation services; and

3. Telephone relay systems.

G. A Member may withdraw a Complaint at any time before CalOptima renders a decision by notifying CalOptima's GARS Department, in writing.

IV. ATTACHMENT(S)

A. Complaint Misclassification Letter
B. OneCare Member Request, Appeal, or Complaint Form

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy MA.1001: Glossary of Terms
C. CalOptima Policy MA.9002: Member Grievance Process
D. CalOptima Policy MA.9003: Standard Appeal
E. CalOptima Policy MA.9004: Expedited Appeal
F. CalOptima Policy MA.9005: Payment Appeal
G. Medicare Managed Care Manual, Chapter 13, Section 20
H. Prescription Drug Benefit Manual, Chapter 18, Section 20
I. Title 42, Code of Federal Regulations, §422.560 et. seq.

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	08/01/2005	MA.9001	Complaint Process	OneCare
Revised	07/01/2010	MA.9001	Complaint Process	OneCare
Revised	10/01/2012	MA.9001	Complaint Process	OneCare
Revised	11/01/2016	MA.9001	Complaint Process	OneCare
Revised	02/01/2018	MA.9001	Complaint Process	OneCare

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Action	Date	Policy	Policy Title	Program(s)
RETIRED	04/01/2022	MA.9001	Complaint Process	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse organization determination on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service. These procedures include reconsideration by CalOptima and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.
Authorized Representative	Any individual appointed by a Member, or authorized under state or other applicable law, to act on behalf of a member in an organization or coverage determination, grievance, or appeal.
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or CalOptima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Coverage Determination	Any decision, or failure to decide in a timely manner, made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled.
Grievance	Any Complaint or dispute, other than an organization or coverage determination or late enrollment penalty determination, expressing dissatisfaction with the manner in which CalOptima, its providers or delegated entities provides health care services, or the operations, activities, or behavior, regardless of whether any remedial action can be taken.
Member	An enrollee-beneficiary of the CalOptima OneCare program.

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Term	Definition
Organization Determination	Any determination made by CalOptima with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima. 3. CalOptima's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima; 4. Reduction or premature discontinuation of a previously authorized service; or 5. CalOptima's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs).

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for Ratification or Retirement

OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

[Date]

[Name]
[Address]
[City, State Zip Code]

Re: [Member Name, I.D. #]

Dear [Name]:

Thank you for your patience during OneCare's review of your inquiry. It has been determined that your inquiry was misclassified as [an appeal; an expedited appeal; an expedited grievance; a grievance]. Therefore, your concerns will be processed utilizing the [appeal; expedited appeal; grievance; expedited grievance] procedure. We apologize for any inconvenience that this situation may have caused you.

We take your concerns very seriously, as we use them to identify areas within our system that need attention. You are our most important source of information in OneCare's continuous quality improvement process. We use your input to initiate changes and improvements to ensure quality service for all our members.

Once we have concluded our research, you will be notified of the outcome. Please feel free to contact me at 1-[Area Code]-[Phone number], should you have any additional information concerning your situation. You may also call the Customer Service Department toll free at 1-877-412-2734, 24 hours a day, 7 days a week; or visit our office Monday through Friday, 8 am to 5 pm. TTY/TDD users may call 1-800-735-2929.

Thank you for giving us a chance to improve our service to you.

Sincerely,

[Specialist Name], Resolution Specialist
Grievance and Appeals Resolution Services

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for Ratification of Retirement

H5433_OC-05135E Approved (6/01/05)

OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract and a contract with the California Medi-Cal (Medicaid) program. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-877-412-2734**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-412-2734** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-412-2734** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-412-2734** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-877-412-2734** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-877-412-2734** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-412-2734** (телетайп: **1-800-735-2929**).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-412-2734** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم
1-877-412-2734 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ

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ਹੈ। **1-877-412-2734** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল□য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল□ আছ। ◌েফান করন **1-877-412-2734** (TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-877-412-2734** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-412-2734** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-412-2734** (TTY: **1-800-735-2929**).

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OneCare (HMO SNP)
CalOptima
A Public Agency
Better. Together.

Member Request, Appeal or Complaint Form

Use this form to request a coverage decision, appeal, or to file a formal complaint for any part of care or service you had from OneCare. Complete and return this form to us in person, by mail or fax to 1-714-481-6499.

Print clearly or type below:

_____ _____
Member Name *(First)* *(Middle initial)* *(Last)* CIN #

_____
Mailing Address *(City)* *(State)* *(Zip Code)*

(_____)_____ _____
Phone Number Date of Birth *(MM/DD/YY)*

Briefly describe the reason for your appeal, complaint, or request (including requests for exception of our drug coverage) - state the service, drug name, dates, times, persons, places, etc. Provide exact details and use a second sheet of paper if needed. Attach copies of any letters, details or records that will support your complaint or request. Be sure to write your name and CIN# on all pages.

_____
_____
_____
_____
_____
_____

Date_____ **Signature**_____

If you have any questions, please call the OneCare (HMO SNP) Customer Service Department toll-free at 1-877-412-2734, 24 hours a day, 7 days a week or visit our office Monday through Friday 8:00 a.m. to 5:00 p.m. at 505 City Parkway West, Orange, CA 92868. TTY/TDD users please call 1-800-735-2929.

Note: If you have someone other than your doctor or prescriber file your request, please complete and submit the **Appointment of Representative Form** which can be printed from the CalOptima OneCare website at www.caloptima.org or by calling the OneCare Customer Service Department toll-free at 1-877-412-2734. Please refer to your Evidence of Coverage book for complete information on what to do if you have a problem or complaint.

For 20220505 BOD Review for Ratification of Retirement

What If I Don't Agree With This Decision?

You have the right to appeal. File your appeal in writing within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May File an Appeal?

You or your treating physician may file an appeal. You can name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative. Others also already may be authorized under State law to act for you.

If you have any questions, please call the OneCare Customer Service Department toll-free at 1-877-412-2734, 24 hours a day, 7 days a week or visit our office Monday through Friday, 8:00 a.m. to 5:00 p.m. Members with speech or hearing impairments can call 1-800-735-2929.

If you want someone to act for you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

For 20220505 BOD Review for Ratification of Retirement

Important Information About Your Appeal Rights

For more information about your appeal rights, call us or see your Evidence of Coverage.

There are two kinds of appeals you can file:

Standard (30 days) – You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Fast (72 hour review) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- **If any doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal**.
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 days.

What Do I Include With My Appeal?
Your written request should include: your name, address, member number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send this information or present this information in person.

How Do I File an Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to the address(es) below:

Grievance & Appeal Resolution Services
CalOptima
505 City Parkway West
Orange, CA 92868

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax:
1-877-412-2734

What Happens Next? If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of OneCare. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 8:00 a.m. to 5:30 p.m. at:

Toll Free: 1-877-412-2734
TTY/TTD: 1-800-735-2929

Other Resources To Help You:
Medicare Rights Center:
Toll Free: 1-888-HMO-9050

Elder Care Locator:
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY/TTD: 1-877-486-2048

For 2022.05.05 BOD Review
for Ratification of Retirement

Policy:	MA.9002
Title:	**Member Grievance Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review for Ratification

I. PURPOSE

This policy defines the process by which CalOptima shall address and resolve a Member's Grievance, in accordance with applicable statutory~~,~~ provisions, and the regulatory~~,~~ and contractual requirements~~.~~ of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

~~A.~~ CalOptima shall establish and maintain a process ~~pursuant to which a Member may submit a Grievance for review and resolution.~~ that addresses

~~B.~~A. ~~CalOptima's Grievance process shall address~~ the receipt, handling, and disposition of Grievances, in accordance with applicable statutes, regulations, contractual requirements, and this ~~policy.~~Policy.

~~C.~~B. Grievance and Appeals Resolution Services (GARS) staff shall review and investigate Grievances.

C. Subject to the provisions of this Policy, a Grieving Party has the right to file a Grievance involving the express dissatisfaction with any aspect of the operations, activities, or behavior of CalOptima or its delegated entity(s) in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested.

1. Grievances may involve, but are not limited to the following instances:

a. A Member's involuntary disenrollment initiated by CalOptima;

b. A change in premiums or cost sharing arrangements from one contract year to the next;

c. Lack of quality of the care received;

d. Plan benefit design;

e. Difficulty contacting CalOptima via phone;

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f. Interpersonal aspects of care;

g. CalOptima's Appeals process;

h. CalOptima's decision not to expedite a coverage or Appeal request;

i. General dissatisfaction about a co-payment amount, but not a dispute about the amount the Member paid or is billed;

j. General issues about a drug not being on the formulary or listed as an excluded drug; or

k. Calculation of True Out-of-Pocket (TrOOP) costs for Medicare Part D drugs. A Member may track TrOOP expenditures for covered Part D drugs in accordance with CalOptima Policy MA.6109: True Out-of-Pocket Expenditures.

D. Subject to the provisions of this Policy, decisions made under the Grievance process are not subject to Appeal.

E. A Grieving Party must file a Grievance (including Quality of Care Grievances), verbally or in writing, no later than sixty (60) calendar days after the event or incident that precipitates the Grievance.

~~D.~~F. Other CalOptima departments, Health Networks and Providers shall respond to a GARS staff request for information relating to a Grievance within the timeframe specified by GARS.

~~E. Except as provided in Section II.F. of this policy, CalOptima shall process a Grievance within thirty (30) calendar days after receipt of the Grievance.~~

~~1. A Member or a Member's Authorized Representative may request an expedited Grievance if:~~

~~a. An expedited request for an Organization or Coverage Determination is denied, or an extension is declined.~~

~~b. CalOptima determines that a Member's request for an expedited Appeal fails to meet expedited criteria, in accordance with CalOptima Policy MA.9004: Expedited Service Appeal, and decides to process the Member's request as a standard appeal, in accordance with CalOptima Policy MA.9003: Standard Service Appeal; or~~

~~c. CalOptima determines that it requires a fourteen (14) day extension to process a Member's request for Appeal.~~

~~2. CalOptima shall process an expedited Grievance within twenty-four (24) hours after receipt of such expedited Grievance.~~

~~F. If a Grievance involves quality of care, GARS staff shall send a Quality Improvement referral to the Quality Improvement (QI) Department for investigation.~~

G. Member Notice

1. CalOptima shall notify a Member of the Grievance process upon initial enrollment, and annually thereafter, in the OneCare Member Handbook/Evidence of Coverage~~;~~.

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2. The Customer Service Department shall inform a Member of the Grievance process upon the Member's involuntary disenrollment from OneCare~~,~~ in accordance with CalOptima Policy MA.4004: Member Disenrollment.

3. The CalOptima Utilization Management Department~~,~~ or the Member's Health Network~~,~~ shall notify a Member of the Grievance process upon denial of the Member's request for an expedited review~~; and~~.

4. CalOptima and a Health Network shall inform a Member of the Grievance process upon the Member's request for such information.

H. Upon request from a Member or Provider, GARS staff shall provide:

1. Information on how a Member may file a Grievance;

2. The OneCare Member ~~Request~~request, Appeal, or ~~Complaint~~Grievance Form to a Member, or a Provider; and

3. Assistance to a Member who wishes to file a Grievance.

I. CalOptima shall ensure that there is no discrimination against a Member on the basis that such Member filed a Grievance, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

J. CalOptima shall ensure that Members have equal access to, and can fully participate in, the Grievance process by providing assistance to Members with limited English proficiency, vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

~~J.~~K. CalOptima shall maintain Member Confidentiality throughout the Grievance process.

L. CalOptima may consult with its legal counsel prior to responding to a Member's Grievance.

~~II.I. PROCEDURE~~

M. ~~CalOptima shall classify a Complaint as~~ A Grieving Party may file a Grievance~~, in accordance with CalOptima Policy MA.9001: Complaint Process. Upon classification~~ regarding quality of care to CalOptima or to the Quality Improvement Organization (QIO).

N. If a Grievance involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

III. PROCEDURE

A. Parties to a Grievance

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1. A Member or an individual appointed by the Member (e.g., relative, friend, advocate, attorney) acting as the Member's Authorized Representative may file a Grievance. If an Authorized Representative files a Grievance, he or she shall submit documentation of such appointment, as follows:

   a. Appropriate legal documents, or authority, supporting such appointment; or

   b. Appointment of Representative Form or equivalent written notice (Representative Form) signed by both the Member and the Member's Authorized Representative, except if an attorney acts as the Member's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form, or equivalent written notice, signed by the Member only.

2. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Member in filing a Grievance.

   a. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

   b. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

B. Filing a Grievance

1. A Grieving Party may file a Grievance:

   a. Verbally, by telephone, or in person with the Customer Service Department; or

   b. In writing to the GARS department.

2. A Grievance shall be considered received on the date and time:

   a. CalOptima initially stamps a document received by regular mail;

   b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document;

   c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

   d. A verbal request is made by telephone with Customer Service;

   e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

   f. A Grievance is received through CalOptima's website.

3. Expedited Grievance

   a. A Grieving Party may request an expedited Grievance if:

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i. An expedited request for an Organization or Coverage Determination is denied, or an extension is taken;

ii. CalOptima determines that a Member's request for an expedited Appeal fails to meet expedited criteria, in accordance with CalOptima Policy MA.9004: Expedited Pre-Service Appeal and decides to process the Member's request as a standard Appeal, in accordance with CalOptima Policy MA.9003: Standard Pre-Service Appeal; or

iii. CalOptima determines that it requires a fourteen (14)-day extension to process a Member's request for a standard or expedited pre-service Appeal.

4. Any unit within CalOptima or a delegated entity not responsible for processing Grievances that incorrectly receives a Grievance, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

C. Grievance Timeframe

1. Standard Grievance

a. Subject to the provisions of this ~~policy~~Policy, CalOptima shall complete the investigation and resolve a Grievance (including Quality of Care Grievances) filed by a Grieving Party, as expeditiously as the Member's case requires, based on the Member's health status, but no later than thirty (30) calendar days after receipt of such request, unless a fourteen (14) calendar day extension is requested by the Grieving Party or if CalOptima justifies a need for additional information and documents how the delay is in the best interest of the Member.

1. If CalOptima determines that an extension will be taken, GARS staff shall promptly notify the Member, in writing, and explain the reason for the extension and the Member's right to request an expedited Grievance if the Member disagrees with the time extension.

b. The standard Grievance processing timeframe begins when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives a Grievance.

2. Expedited Grievance

a. Subject to the provisions of this Policy, CalOptima shall complete the investigation and resolve an expedited Grievance filed by a Grieving Party, as expeditiously as the Member's case requires, based on the Member's health status, but no later than twenty-four (24) hours after receipt of such request.

b. The expedited Grievance processing timeframe begins when the appropriate CalOptima department receives such request.

D. Grievance Processing

1. Upon receipt of a Grievance, GARS staff shall:

a. Enter the information in the database; and

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~~B.~~A. ~~Grievance Processing~~

~~1. Upon receipt of a Grievance, GARS staff shall:~~

~~a. Enter the information in the database; and~~

b. Contact the Member to obtain any missing information or evidence concerning the Grievance and enter such information ~~in~~into the database.

2. Except in the case of an expedited Grievance, GARS staff ~~shall send~~ respond to the Grievance in writing, by sending a Grievance ~~Acknowledgement Letter~~acknowledgement letter to the Member within five (5) business days ~~upon~~after CalOptima's receipt of the Grievance. The acknowledgement letter shall:

a. Confirm receipt of the Grievance;

b. Provide the name of the GARS staff assigned to the Grievance; and

c. Indicate the estimated timeframe to research and resolve the Grievance.

3. If any type of Representative Form is not received by the thirty (30) calendar day resolution or fourteen (14) calendar day extension standard timeframe, or the twenty-four (24) hour expedited timeframe, CalOptima will not issue a decision until or unless such documentation is obtained.

a. GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Member's Authorized Representative.

b. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, GARS staff shall make at least two (2) telephone calls to the requestor in an attempt to obtain the documentation.

c. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative after retrieval attempts, CalOptima shall dismiss the Grievance and notify the Member, in writing, that the request for Grievance shall be dismissed due to lack of the required documentation to process the Grievance.

4. If CalOptima determines that it misclassified a Member's Grievance as an Appeal, it shall notify the Member, in writing, of the misclassified Grievance, and shall process the reclassified Grievance through the Grievance process. CalOptima shall consider the date of receipt of the original request as the date of receipt of the Grievance.

~~C.~~E. Grievance Investigation

1. The GARS staff shall forward a Member Complaint Referral to the responsible department, Health Network, or Provider, as applicable, for investigation and resolution.

2. The responsible department, Health Network, or Provider~~,~~ shall respond to the GARS staff within the timeframe specified by the referring GARS staff.

3. Upon receipt of the responsible department's, Health Network's, or Provider's, investigation and resolution of a Grievance, the GARS Director~~,~~ or his or her Designee~~,~~ shall review the Grievance for completeness and appropriate designation.

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D.F. Grievance Resolution

Subject to the provisions of this policy, CalOptima

1. GARS shall resolve prepare, in writing, a resolution letter, addressing all issues raised in the Grievance, and and written in a manner that is understandable to the Member, upon completion of the investigation..

1. Standard Grievance (Including Quality of Care Grievances): GARS staff shall provide the Member withGrieving Party a Grievance Resolution Letter, within no later than thirty (30) calendar days after receipt of the Grievance.
, or no later than forty-four (44
a. If CalOptima determines that it requires a fourteen (14) calendar daydays, ifdays if an extension, it shall notify the Member, or Member's Authorized Representative, in writing, of the reason for is applied.

a.b. Expedited Grievance: GARS staff shall provide the extension and Grieving Party verbal notification of the Member's right to request an expedited Grievance if the Member disagrees with the time extension. decision no later than twenty-four (24) hours after receipt of such request, and provide the Grieving Party, in writing, a Grievance Resolution Letter, no later than three (3) calendar days of the verbal notification.

2. CalOptima shall respond to an expedited If a Grievance within twenty-four (24) hours after receipt (including Quality of such expedited Grievance.
Care Grievances) was
c. CalOptima shall respond to a Complaint related to quality of care, in writing, regardless of whether the Complaint is filed orally, or in writing. The written response shall include a description ofby the Member's right to file a written Complaint with the Quality Improvement Organization.Authorized Representative, the Authorized Representative must be notified.

K.A. CalOptima may consult with its legal counsel prior to responding to a Member's Grievance.

3. GARS staff shall notify the Quality Improvement (QI) Department of all Grievances involving Providers for use in the Recredentialing process and for other evaluation and tracking purposes.

2. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

3. CalOptima shall consider a Grievance to be closed when:

a. The problem is resolved;

b. CalOptima takes appropriate action to implement the decision; or

c. The Member withdraws the Grievance.

4. Upon closure of the Grievance, GARS staff shall close the case in the database by entering the case summary, closure date, category, and resolution status.

G. Quality of Care Grievances

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1. If a Grievance involves quality of care, GARS staff shall send a Quality Improvement referral to the Quality Improvement (QI) Department for investigation in accordance CalOptima Policy: GG.1611: Potential Quality Issue Review Process.

2. CalOptima shall respond to a Grievance related to quality of care, in writing, regardless of whether the Grievance is filed orally, or in writing. The written response shall include a description of the Member's right to file a written Grievance with the QIO.

3. GARS staff shall notify the Quality Improvement (QI) Department of all Grievances involving Providers for use in the Recredentialing process and for other evaluation and tracking purposes.

4. CalOptima shall notify a Member of the Grievance process available to the Member through the QIO upon initial enrollment and annually thereafter, in the OneCare Member Handbook/Evidence of Coverage.

5. If a Member files a Grievance regarding quality of care to the QIO, CalOptima shall cooperate with the QIO to resolve the Grievance.

H. Grievance Withdrawals

1. A Grieving Party may submit a written withdrawal request or verbal withdrawal for both written and verbal Grievances at any time before the decision is mailed by CalOptima.

2. CalOptima must clearly document in the system that the Member does not want to proceed with Grievance procedures.

3. CalOptima shall, but is not required to, send a written confirmation of that withdrawal to the Member within three (3) calendar days of receiving the withdrawal request.

4. If the Member submits a quality of care Grievance verbally or in writing, but later decides to withdraw the Grievance, CalOptima is still required to investigate the quality of care Grievance; however, CalOptima is not required to notify the Member of the outcome of the Grievance since they decided not to pursue it.

~~H.~~I. GARS shall refer a Grievance to the Office of Compliance ~~or~~, Provider Relations Department, or the Network Management Department if:

1. A CalOptima department, ~~or~~a Health Network, or a Provider, fails to submit requested information within the specified timeframe;

2. The Grievance is recurrent;

3. The Grievance remains unresolved; or

4. The Grievance necessitates disciplinary action.

~~I.~~J. Grievance Reporting

1. CalOptima shall categorize Grievances according to type.

2. GARS shall generate monthly reports of Grievances according to:

   a. Resolution status;

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b. Grievance type;

c. Provider; and

d. Number of calendar days to close the case.

3. GARS shall report quarterly aggregated data on Grievances to the Grievance and Appeal Resolution Committee for analysis and identification of trends and quality improvement opportunities.

4. CalOptima shall report aggregated Grievance data to state and federal agencies, as required. Such reports shall:

a. Exclude personal, or Confidential, information with respect to any Member; and

b. Comply with formatting requirements specified by the state or federal agency. Information may include, but not limited to, the number and types of Grievances and resolutions.

6. Upon request, CalOptima shall provide aggregate Grievance data to a Member. CalOptima shall maintain Confidentiality by excluding all Member identification from such data. CalOptima may provide the following types of data to Members:

a. Number of Grievances per one thousand (1,000) Members; and

b. Number of Grievances involving quality of care in a specified time period.

K. Complaint and Resolution Tracking

1. GARS will be responsible for receiving, responding to, and tracking complaints from the Complaint Tracking Module (CTM) in the Health Plan Management System administered by the Centers for Medicare and Medicaid Services (CMS).

L. Grievance Records

1. CalOptima shall maintain written records of each Grievance. Such records shall include at least the following information:

a. Date of receipt;

b. Member's name;

c. Name of the CalOptima employee assigned as the contact person;

d. Description of the Grievance;

e. Disposition of the Grievance; and

f. Copy of all Medical Records, documents, evidence of coverage, and other relevant information CalOptima used to render its decision.

2. CalOptima shall maintain written records of each Grievance, including copies of Grievances and responses thereto, for a period of ten (10) years after the end of the fiscal year in which CalOptima's contract with Centers for Medicare & Medicaid Services terminates.

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IV. ATTACHMENTS(S)

~~A. OneCare Member Request, Appeal, or Complaint Form~~
~~B. Grievance Acknowledgement Letter~~
~~C. Member Complaint Referral~~
~~D. Grievance Resolution Letter~~
Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy GG.1611: Potential Quality Issue Review Process
C. CalOptima Policy HH.1104: Complaints of Discrimination
D. CalOptima Policy MA.1001: OneCare Glossary of Terms
E. CalOptima Policy MA.4002: Cultural and Linguistic Services
F. CalOptima Policy MA.4004: Member Disenrollment
G. CalOptima Policy MA.6109: True Out-of-Pocket Expenditures
~~B.~~H. CalOptima Policy MA.9001: Complaint Process
I. CalOptima Policy MA.9003: Standard Pre-Service Appeal
J. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
~~C.~~K. Medicare Managed Care Manual, Chapter 13
~~D.~~L. OneCare Member Handbook/Evidence of Coverage
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
~~E.~~N. Prescription Drug Benefit Manual, Chapter 18
~~F.~~O. Title 42, Code of Federal Regulations, ~~§§~~ 422.111(c)(3), and 422.560, 422.564(e)(2), 423.564(e)(2) et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/01/2022	Regular Meeting of the CalOptima Board of Directors

~~None to Date~~

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.9002	Member Grievance Process	OneCare
Revised	07/01/2010	MA.9002	Member Grievance Process	OneCare
Revised	10/01/2012	MA.9002	Member Grievance Process	OneCare
Revised	11/01/2016	MA.9002	Member Grievance Process	OneCare
Revised	02/01/2018	MA.9002	Member Grievance Process	OneCare
Revised	04/01/2022	MA.9002	Member Grievance Process	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse ~~organization~~initial determination made by CalOptima on ~~the~~ health care services ~~a member~~or benefits under Part C the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services ~~(such that~~ or drug coverage (when a delay would adversely affect the health of the ~~member~~Member), or on any amounts the ~~member~~Member must pay for a service~~.~~ or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration by ~~CalOptima and if necessary,~~ an independent review entity~~, hearings before~~ (IRE), adjudication by an Administrative Law ~~Judges (ALJs),~~Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by CalOptima.
Authorized Representative	~~Any individual appointed by a Member, or authorized under state or other applicable law, to act on behalf of a member in an organization or coverage determination, grievance, or appeal.~~ 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.
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. ~~A Complaint may include concerns about the operations of Providers or CalOptima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered.~~ A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Confidential or Confidentiality	Means the property that data or information is not made available or disclosed to unauthorized persons or processes.
Coverage Determination	~~Any~~A decision~~, or failure to decide in a timely manner,~~ made by ~~or on behalf of a Part D~~the plan ~~sponsor regarding~~, or its delegated entity, on a request for coverage (payment or ~~benefits to which~~ provision) of an ~~enrollee believes he or she is entitled~~item, service, or drug.
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.

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Term	Definition
Grievance	~~Any Complaint or dispute, other than an organization or coverage determination or late enrollment penalty determination, expressing~~ An expression of dissatisfaction with ~~the manner in which CalOptima, its providers or delegated entities provides health care services, or~~ 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 ~~any~~ remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization or an LEP determination.
Grieving Party	For purposes of this Policy, a Member, or a Member's Authorized Representative.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
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~~ A beneficiary ~~of the OneCare~~enrolled in a CalOptima program.
Organization Determination	Any determination made by OneCare with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare. 3. OneCare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and/or 5. OneCare's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, ~~Physician Medical Group~~Health Network, or other person or institution who furnishes Covered Services.

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Term	Definition
Quality of Care Grievance	A type of Grievance that is related to whether the quality of covered services provided by CalOptima or provider meets professionally recognized standards of health care.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.
~~Reason Code~~Representative Form	~~The alpha/numeric codes used to identify each issue within a Member's Appeal or Grievance.~~For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.
Threshold Languages	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.

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Policy:	MA.9002
Title:	**Member Grievance Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the process by which CalOptima shall address and resolve a Member's Grievance, in accordance with applicable statutory provisions, and the regulatory and contractual requirements of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima shall establish and maintain a process that addresses the receipt, handling, and disposition of Grievances, in accordance with applicable statutes, regulations, contractual requirements, and this Policy.

B. Grievance and Appeals Resolution Services (GARS) staff shall review and investigate Grievances.

C. Subject to the provisions of this Policy, a Grieving Party has the right to file a Grievance involving the express dissatisfaction with any aspect of the operations, activities, or behavior of CalOptima or its delegated entity(s) in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested.

1. Grievances may involve, but are not limited to the following instances:

   a. A Member's involuntary disenrollment initiated by CalOptima;

   b. A change in premiums or cost sharing arrangements from one contract year to the next;

   c. Lack of quality of the care received;

   d. Plan benefit design;

   e. Difficulty contacting CalOptima via phone;

   f. Interpersonal aspects of care;

   g. CalOptima's Appeals process;
   h. CalOptima's decision not to expedite a coverage or Appeal request;

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i. General dissatisfaction about a co-payment amount, but not a dispute about the amount the Member paid or is billed;

j. General issues about a drug not being on the formulary or listed as an excluded drug; or

k. Calculation of True Out-of-Pocket (TrOOP) costs for Medicare Part D drugs. A Member may track TrOOP expenditures for covered Part D drugs in accordance with CalOptima Policy MA.6109: True Out-of-Pocket Expenditures.

D. Subject to the provisions of this Policy, decisions made under the Grievance process are not subject to Appeal.

E. A Grieving Party must file a Grievance (including Quality of Care Grievances), verbally or in writing, no later than sixty (60) calendar days after the event or incident that precipitates the Grievance.

F. Other CalOptima departments, Health Networks and Providers shall respond to a GARS staff request for information relating to a Grievance within the timeframe specified by GARS.

G. Member Notice

1. CalOptima shall notify a Member of the Grievance process upon initial enrollment, and annually thereafter, in the OneCare Member Handbook/Evidence of Coverage.

2. The Customer Service Department shall inform a Member of the Grievance process upon the Member's involuntary disenrollment from OneCare in accordance with CalOptima Policy MA.4004: Member Disenrollment.

3. The CalOptima Utilization Management Department or the Member's Health Network shall notify a Member of the Grievance process upon denial of the Member's request for an expedited review.

4. CalOptima and a Health Network shall inform a Member of the Grievance process upon the Member's request for such information.

H. Upon request from a Member or Provider, GARS staff shall provide:

1. Information on how a Member may file a Grievance;

2. The OneCare Member request, Appeal, or Grievance Form to a Member, or a Provider; and

3. Assistance to a Member who wishes to file a Grievance.

I. CalOptima shall ensure that there is no discrimination against a Member on the basis that such Member filed a Grievance, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

J. CalOptima shall ensure that Members have equal access to, and can fully participate in, the Grievance process by providing assistance to Members with limited English proficiency, vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

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2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

K. CalOptima shall maintain Member Confidentiality throughout the Grievance process.

L. CalOptima may consult with its legal counsel prior to responding to a Member's Grievance.

M. A Grieving Party may file a Grievance regarding quality of care to CalOptima or to the Quality Improvement Organization (QIO).

N. If a Grievance involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

III. PROCEDURE

A. Parties to a Grievance

1. A Member or an individual appointed by the Member (e.g., relative, friend, advocate, attorney) acting as the Member's Authorized Representative may file a Grievance. If an Authorized Representative files a Grievance, he or she shall submit documentation of such appointment, as follows:

   a. Appropriate legal documents, or authority, supporting such appointment; or

   b. Appointment of Representative Form or equivalent written notice (Representative Form) signed by both the Member and the Member's Authorized Representative, except if an attorney acts as the Member's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form, or equivalent written notice, signed by the Member only.

2. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Member in filing a Grievance.

   a. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

   b. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

B. Filing a Grievance

1. A Grieving Party may file a Grievance:

   a. Verbally, by telephone, or in person with the Customer Service Department; or

   b. In writing to the GARS department.

2. A Grievance shall be considered received on the date and time:

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a. CalOptima initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document;

c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

f. A Grievance is received through CalOptima's website.

3. Expedited Grievance

a. A Grieving Party may request an expedited Grievance if:

i. An expedited request for an Organization or Coverage Determination is denied, or an extension is taken;

ii. CalOptima determines that a Member's request for an expedited Appeal fails to meet expedited criteria, in accordance with CalOptima Policy MA.9004: Expedited Pre-Service Appeal and decides to process the Member's request as a standard Appeal, in accordance with CalOptima Policy MA.9003: Standard Pre-Service Appeal; or

iii. CalOptima determines that it requires a fourteen (14)-day extension to process a Member's request for a standard or expedited pre-service Appeal.

4. Any unit within CalOptima or a delegated entity not responsible for processing Grievances that incorrectly receives a Grievance, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

C. Grievance Timeframe

1. Standard Grievance

a. Subject to the provisions of this Policy, CalOptima shall complete the investigation and resolve a Grievance (including Quality of Care Grievances) filed by a Grieving Party, as expeditiously as the Member's case requires, based on the Member's health status, but no later than thirty (30) calendar days after receipt of such request, unless a fourteen (14) calendar day extension is requested by the Grieving Party or if CalOptima justifies a need for additional information and documents how the delay is in the best interest of the Member.

1. If CalOptima determines that an extension will be taken, GARS staff shall promptly notify the Member, in writing, and explain the reason for the extension and the Member's right to request an expedited Grievance if the Member disagrees with the time extension.

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b. The standard Grievance processing timeframe begins when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives a Grievance.

2. Expedited Grievance

a. Subject to the provisions of this Policy, CalOptima shall complete the investigation and resolve an expedited Grievance filed by a Grieving Party, as expeditiously as the Member's case requires, based on the Member's health status, but no later than twenty-four (24) hours after receipt of such request.

b. The expedited Grievance processing timeframe begins when the appropriate CalOptima department receives such request.

D. Grievance Processing

1. Upon receipt of a Grievance, GARS staff shall:

a. Enter the information in the database; and

b. Contact the Member to obtain any missing information or evidence concerning the Grievance and enter such information into the database.

2. Except in the case of an expedited Grievance, GARS staff respond to the Grievance in writing, by sending a Grievance acknowledgement letter to the Member within five (5) business days after CalOptima's receipt of the Grievance. The acknowledgement letter shall:

a. Confirm receipt of the Grievance;

b. Provide the name of the GARS staff assigned to the Grievance; and

c. Indicate the estimated timeframe to research and resolve the Grievance.

3. If any type of Representative Form is not received by the thirty (30) calendar day resolution or fourteen (14) calendar day extension standard timeframe, or the twenty-four (24) hour expedited timeframe, CalOptima will not issue a decision until or unless such documentation is obtained.

a. GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Member's Authorized Representative.

b. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, GARS staff shall make at least two (2) telephone calls to the requestor in an attempt to obtain the documentation.

c. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative after retrieval attempts, CalOptima shall dismiss the Grievance and notify the Member, in writing, that the request for Grievance shall be dismissed due to lack of the required documentation to process the Grievance.

4. If CalOptima determines that it misclassified a Member's Grievance as an Appeal, it shall notify the Member, in writing, of the misclassified Grievance, and shall process the reclassified Grievance through the Grievance process. CalOptima shall consider the date of receipt of the original request as the date of receipt of the Grievance.

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E. Grievance Investigation

1. The GARS staff shall forward a Member Complaint Referral to the responsible department, Health Network, or Provider, as applicable, for investigation and resolution.

2. The responsible department, Health Network, or Provider shall respond to the GARS staff within the timeframe specified by the referring GARS staff.

3. Upon receipt of the responsible department's, Health Network's, or Provider's, investigation and resolution of a Grievance, the GARS Director or his or her Designee shall review the Grievance for completeness and appropriate designation.

F. Grievance Resolution

1. GARS shall prepare, in writing, a resolution letter, addressing all issues raised in the Grievance and written in a manner that is understandable to the Member, upon completion of the investigation.

   a. Standard Grievance (Including Quality of Care Grievances): GARS staff shall provide the Grieving Party a Grievance Resolution Letter no later than thirty (30) calendar days after receipt of the Grievance, or no later than forty-four (44) calendar days if an extension is applied.

   b. Expedited Grievance: GARS staff shall provide the Grieving Party verbal notification of the expedited Grievance decision no later than twenty-four (24) hours after receipt of such request, and provide the Grieving Party, in writing, a Grievance Resolution Letter, no later than three (3) calendar days of the verbal notification.

   c. If a Grievance (including Quality of Care Grievances) was filed by the Member's Authorized Representative, the Authorized Representative must be notified.

2. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter

3. CalOptima shall consider a Grievance to be closed when:

   a. The problem is resolved;

   b. CalOptima takes appropriate action to implement the decision; or

   c. The Member withdraws the Grievance.

4. Upon closure of the Grievance, GARS staff shall close the case in the database by entering the case summary, closure date, category, and resolution status.

G. Quality of Care Grievances

1. If a Grievance involves quality of care, GARS staff shall send a Quality Improvement referral to the Quality Improvement (QI) Department for investigation in accordance CalOptima Policy: GG.1611: Potential Quality Issue Review Process.

2. CalOptima shall respond to a Grievance related to quality of care, in writing, regardless of whether the Grievance is filed orally, or in writing. The written response shall include a description of the Member's right to file a written Grievance with the QIO.

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3. GARS staff shall notify the Quality Improvement (QI) Department of all Grievances involving Providers for use in the Recredentialing process and for other evaluation and tracking purposes.

4. CalOptima shall notify a Member of the Grievance process available to the Member through the QIO upon initial enrollment and annually thereafter, in the OneCare Member Handbook/Evidence of Coverage.

5. If a Member files a Grievance regarding quality of care to the QIO, CalOptima shall cooperate with the QIO to resolve the Grievance.

H. Grievance Withdrawals

1. A Grieving Party may submit a written withdrawal request or verbal withdrawal for both written and verbal Grievances at any time before the decision is mailed by CalOptima.

2. CalOptima must clearly document in the system that the Member does not want to proceed with Grievance procedures.

3. CalOptima shall, but is not required to, send a written confirmation of that withdrawal to the Member within three (3) calendar days of receiving the withdrawal request.

4. If the Member submits a quality of care Grievance verbally or in writing, but later decides to withdraw the Grievance, CalOptima is still required to investigate the quality of care Grievance; however, CalOptima is not required to notify the Member of the outcome of the Grievance since they decided not to pursue it.

I. GARS shall refer a Grievance to the Office of Compliance, Provider Relations Department, or the Network Management Department if:

1. A CalOptima department, a Health Network, or a Provider, fails to submit requested information within the specified timeframe;

2. The Grievance is recurrent;

3. The Grievance remains unresolved; or

4. The Grievance necessitates disciplinary action.

J. Grievance Reporting

1. CalOptima shall categorize Grievances according to type.

2. GARS shall generate monthly reports of Grievances according to:

a. Resolution status;

b. Grievance type;

c. Provider; and

d. Number of calendar days to close the case.

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3. GARS shall report quarterly aggregated data on Grievances to the Grievance and Appeal Resolution Committee for analysis and identification of trends and quality improvement opportunities.

4. CalOptima shall report aggregated Grievance data to state and federal agencies, as required. Such reports shall:

   a. Exclude personal, or Confidential, information with respect to any Member; and

   b. Comply with formatting requirements specified by the state or federal agency. Information may include, but not limited to, the number and types of Grievances and resolutions.

6. Upon request, CalOptima shall provide aggregate Grievance data to a Member. CalOptima shall maintain Confidentiality by excluding all Member identification from such data. CalOptima may provide the following types of data to Members:

   a. Number of Grievances per one thousand (1,000) Members; and

   b. Number of Grievances involving quality of care in a specified time period.

K. Complaint and Resolution Tracking

1. GARS will be responsible for receiving, responding to, and tracking complaints from the Complaint Tracking Module (CTM) in the Health Plan Management System administered by the Centers for Medicare and Medicaid Services (CMS).

L. Grievance Records

1. CalOptima shall maintain written records of each Grievance. Such records shall include at least the following information:

   a. Date of receipt;

   b. Member's name;

   c. Name of the CalOptima employee assigned as the contact person;

   d. Description of the Grievance;

   e. Disposition of the Grievance; and

   f. Copy of all Medical Records, documents, evidence of coverage, and other relevant information CalOptima used to render its decision.

2. CalOptima shall maintain written records of each Grievance, including copies of Grievances and responses thereto, for a period of ten (10) years after the end of the fiscal year in which CalOptima's contract with Centers for Medicare & Medicaid Services terminates.

IV. ATTACHMENTS(S)

Not Applicable

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V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy GG.1611: Potential Quality Issue Review Process
C. CalOptima Policy HH.1104: Complaints of Discrimination
D. CalOptima Policy MA.1001: OneCare Glossary of Terms
E. CalOptima Policy MA.4002: Cultural and Linguistic Services
F. CalOptima Policy MA.4004: Member Disenrollment
G. CalOptima Policy MA.6109: True Out-of-Pocket Expenditures
H. CalOptima Policy MA.9001: Complaint Process
I. CalOptima Policy MA.9003: Standard Pre-Service Appeal
J. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
K. Medicare Managed Care Manual, Chapter 13
L. OneCare Member Handbook/Evidence of Coverage
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
N. Prescription Drug Benefit Manual, Chapter 18
O. Title 42, Code of Federal Regulations, §§ 422.111(c)(3), and 422.560, 422.564(e)(2), 423.564(e)(2) et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.9002	Member Grievance Process	OneCare
Revised	07/01/2010	MA.9002	Member Grievance Process	OneCare
Revised	10/01/2012	MA.9002	Member Grievance Process	OneCare
Revised	11/01/2016	MA.9002	Member Grievance Process	OneCare
Revised	02/01/2018	MA.9002	Member Grievance Process	OneCare
Revised	04/01/2022	MA.9002	Member Grievance Process	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	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 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 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. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by CalOptima.
Authorized Representative	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.
Complaint	Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Confidential or Confidentiality	Means the property that data or information is not made available or disclosed to unauthorized persons or processes.
Coverage Determination	A decision made by the plan, or its delegated entity, on a request for coverage (payment or provision) of an item, service, or drug.
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.
Grievance	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. A grievance does not include, and is distinct from, a dispute of the appeal of an organization or an LEP determination.
Grieving Party	For purposes of this Policy, a Member, or a Member's Authorized Representative.

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Term	Definition
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
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	A beneficiary enrolled in a CalOptima program.
Organization Determination	Any determination made by OneCare with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare. 3. OneCare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and/or 5. OneCare's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.
Quality of Care Grievance	A type of Grievance that is related to whether the quality of covered services provided by CalOptima or provider meets professionally recognized standards of health care.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.

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Term	Definition
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.
Threshold Languages	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.

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Policy:	MA.9003
Title:	**Standard Pre-Service Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/052005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This ~~policy defines~~Policy addresses Medicare Part C Appeals and describes the process by which CalOptima ensures that Members have clear and reliable access to ~~an~~a standard Appeal process ~~that meets the requirements of~~for Pre-Service Organization Determinations, consistent with the Centers for Medicare & Medicaid Services (CMS~~).~~) requirements.

II. POLICY

A. CalOptima shall establish and maintain a process that addresses the receipt, handling, and disposition of ~~an~~a Part C Appeal, in accordance with applicable statutes, regulations, contractual requirements, and this ~~policy~~Policy.

B. Grievance and Appeals Resolution Services (GARS) staff shall accept, track, and report all Appeals.

C. Subject to the provisions of this ~~policy, a Member, or his or her Authorized Representative, may initiate an Appeal~~Policy, an Appealing Party has the right to request an Appeal of a Pre-Service Organization Determination.

~~D. A physician who provides treatment to a Member may request a standard Appeal of a pre-service request on the Member's behalf. The Member's treating physician shall notify the Member that he or she is requesting a standard Appeal of a pre-service request before submitting the request.~~

~~E.~~D. A Member shall have the right to an attorney, or other representation, in the Appeal process.

~~F.~~E. Subject to the provisions of this ~~policy~~Policy, CalOptima shall process an Appeal within thirty (30) calendar days after receipt of the Appeal.

F. ~~If a Member, his or her Authorized Representative, or treating physician~~The processing timeframe for a standard Appeal shall begin when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives an Appeal request.

G. Subject to the provisions of this Policy, CalOptima shall process an Appeal involving Part B drugs within seven (7) calendar days after receipt of such Appeal type.

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~~G.~~H. If the Appealing Party believes that CalOptima's thirty (30) calendar day Appeal process may seriously jeopardize the Member's life, health, or ability to regain maximum function, the Member, the Member's Authorized Representative, or physician may request an expedited Appeal, in accordance with CalOptima Policy MA.9004: Expedited Pre-Service Appeal.

~~H.~~I. CalOptima shall notify a Member of the Appeal process:

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage (EOC) and periodic Member newsletters;

3. In all notices of adverse Organization Determination;

~~3.~~4. Upon involuntary disenrollment; and

~~4.~~5. Upon the Member's request.

~~I.~~J. Upon request, CalOptima shall provide a Member with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and information used to support CalOptima's decision.

~~J.~~K. All CalOptima departments shall respond promptly, within the designated timeframes, to any inquiry related to an Appeal.

~~K.~~L. CalOptima shall provide all parties to an Appeal with reasonable opportunity to present evidence, or allegations~~,~~ of fact~~,~~ or law, related to the issue in dispute, in person, or in writing. CalOptima shall take all evidence into account when making its decision.

~~L.~~M. CalOptima shall ~~train~~ensure that its Health Networks ~~to~~ direct a Member to CalOptima GARS if the Member requests an Appeal of a CalOptima~~,~~ or Health Network decision.

~~M.~~N. CalOptima shall ensure that there is no discrimination against a Member on the grounds that such Member filed an Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

O. CalOptima shall ensure that Members have equal access to, and can fully participate in, the Appeal process by providing assistance to Members with limited English proficiency, vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

Q. If an Appeal involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

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R. Non-contracted Provider Appeal requests related to claim disputes shall be processed in accordance with CalOptima Policy MA.9009: Non-Contract Provider Payment Disputes.

S. If an Appeal involves an Organization Determination regarding payment for services rendered to a Member, CalOptima shall process such Appeal in accordance with CalOptima Policy MA.9005: Payment Appeal.

T. Any potential quality of care issues shall be referred to the Quality Improvement (QI) Department in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

III. PROCEDURE

A. Parties to ~~an~~a Standard Pre-Service Appeal

~~1. A Member, his or her~~A Member or an individual appointed by the Member (e.g., relative, friend, advocate, attorney) acting as the Member's Authorized Representative~~, or treating physician~~ may file an Appeal.

1. ~~A Member may appoint any individual as his or her Authorized Representative.~~ If an Authorized Representative files an Appeal, he or she shall submit documentation of such appointment, as follows:

a. Appropriate legal documents, or authority, supporting such appointment; or

b. Appointment of Representative Form~~,~~ or ~~similar~~equivalent written ~~statement~~notice (Representative Form) signed by both the Member and the Member's Authorized Representative, except if an attorney acts as the Member's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form, or ~~similar~~equivalent written ~~statement~~notice, signed by the Member only.

2. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Member in filing an Appeal.

a. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

b. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

~~2.~~3. A Provider shall not charge a Member to act as the Member's Authorized Representative.

B. ~~A Member, his or her Authorized Representative, or a physician,~~Request for a Standard Pre-Service Appeal

~~2.~~ An Appealing Party may request an ~~expedited Appeal, in accordance with CalOptima Policy MA.9004: Expedited~~ Appeal~~.~~

~~B. Request for Appeal~~

1. ~~A Member, his or her Authorized Representative, or treating physician, may request an Appeal~~ verbally, by ~~submitting a written request~~telephone, or in person with the Customer Service

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Department, or in writing to CalOptima within sixty (60) calendar days ~~after receipt~~from the date of ~~a~~the notice of ~~an~~the initial adverse Organization Determination.

~~a. CalOptima shall allow a five (5) calendar day grace period for receipt of a mailed request for Appeal.~~

a. CalOptima may accept a request for an Appeal filed after the sixty (60) calendar day limit, if the ~~Member, his or her, Authorized Representative, or treating physician~~Appealing Party submits a written request for an extension of the timeframe for good cause.

i. ~~A Member, his or her~~ In its request for an extension, the Appealing Party must include a statement explaining why the request for Payment Appeal was not filed on time.

ii. If the request for an extension submitted does not include an explanation as to why the request for Payment Appeal was not filed on time, CalOptima may attempt to obtain information supporting good cause for the late filing.

iii. In making its determination, CalOptima should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

iv. CalOptima shall ensure that there is no discrimination against a Member in the determination of good cause justification when an Appeal request is outside the sixty (60) calendar day limit, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

v. Instances where good cause may exist include, but are not limited to:

a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

b) The Appealing Party was seriously ill which prevented a timely Appeal;

c) Death or serious illness in the Appealing Party's immediate family;

d) An accident causing important records to be destroyed;

e) Difficulty in locating and/or receiving necessary documents within the established time limits;

f) Incomplete or incorrect information regarding the Appeal process;

g) The Appealing Party's lack of capacity to understand the Appeal filing timeframe;

h) The Appealing Party sent the request to an incorrect address, in good faith, within the established time limit; or

i) The delay resulted from additional time required to produce Member documents in an accessible format pursuant to CalOptima Policy MA.4002: Cultural and Linguistic Services.

j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program or

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a senior center), on account of his or her disability, in order to be able to file the Appeal.

vi. If CalOptima denies the Appealing Party's request for good cause extension, CalOptima must dismiss such request and the Appealing Party may file a Grievance in accordance with CalOptima Policy MA.9002: Member Grievance Process.

2. An Appeal request shall be considered received on the date and time:

a. When any department within CalOptima initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima (or its designee);

c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

f. An Appeal request is received through CalOptima's website.

~~2.~~3. An Appealing Party~~Authorized Representative, or treating physician~~ may withdraw the request at any time before CalOptima renders a decision by notifying CalOptima of such withdrawal verbally or in writing.

a. If that party withdraws the Appeal request verbally, CalOptima shall mail the party a written confirmation of the withdrawal within three (3) calendar days from the date of the verbal request.

b. If the withdrawal request is received after CalOptima has forwarded the case file to the Independent Review Entity (IRE), then CalOptima must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima or a delegated entity not responsible for processing Appeals that incorrectly receives an Appeal request, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

5. An Appealing Party may request an expedited Appeal, in accordance with CalOptima Policy MA.9004: Expedited Pre-Service Appeal.

C. Standard Pre-Service Appeal Timeframe

1. Subject to the provisions of this ~~policy~~Policy, CalOptima shall make an Appeal determination ~~within~~ , as expeditiously as the Member's case requires, based on the Member's health status, but not later than thirty (30) calendar days ~~after~~upon receipt of a request for ~~Appeal~~an Appeal for items and services, unless a fourteen (14) calendar day extension has been granted. Part B drug timeframes cannot be extended.

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a. The Appeal processing timeframe begins when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives an Appeal request. If such CalOptima unit or delegated entity incorrectly receives an Appeal request, the party shall handle that request in accordance with Section III.B.4. of this Policy.

b. If CalOptima obtains information establishing good cause, the adjudication timeframe of the Appeal request begins on the date CalOptima receives that information.

c. CalOptima shall inform the Member or Member's Authorized Representative of the right to request a fourteen (14) calendar day extension if additional time is needed to submit evidence related to an Appeal.

2. CalOptima may extend the timeframe for an Appeal determination ~~by~~for items and services up to fourteen (14) calendar days upon the Member's request~~,~~ (except for Part B drugs), or if CalOptima needs additional information to make a determination, and such extension is justified and in the Member's interest due to the need for additional medical evidence from a non-contracted Provider that may change CalOptima's decision to deny an item or service, or it is the Member's best interest due to extraordinary, exigent, or other non-routine circumstances, such as a natural disaster. If CalOptima extends the timeframe for an Appeal determination, it shall provide the Member with written notice that includes:

   a. The reason for the extension; and

   b. The Member's right to file an ~~Expedited~~expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process, if he or she disagrees with CalOptima's decision to extend the timeframe.

3. Subject to the provisions of this Policy, CalOptima shall make an Appeal determination for Part B drugs, as expeditiously as the Member's case requires, based on the Member's health status, but not later than seven (7) calendar days after receipt of a request for such Appeal type. Part B drug timeframes cannot be extended.

~~3.~~4. If CalOptima fails to provide ~~a Member, his or her Authorized Representative, or treating physician,~~an Appealing Party with an Appeal determination within the timeframes specified in Sections III.C.1 ~~and III.C.2~~.-3. of this ~~policy~~Policy:

   a. CalOptima shall consider such failure as an affirmation of the adverse Organization Determination; and

   b. CalOptima shall forward the complete case file of the Appeal request ~~for Appeal~~ to the ~~Independent Review Entity (~~IRE~~) within~~ no later than thirty (30) calendar days after receiving the request for Appeal, or ~~within~~no later than forty-four (44) calendar days if CalOptima extended the timeframe, in accordance with Section III.~~C.2~~E.5.b.. of this ~~policy~~Policy.

   c. CalOptima GARS will notify the Appealing Party who requested the Appeal, in writing, that CalOptima forwarded the request to the IRE for final determination by using the model Notice of Appeal Status:

      i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

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ii. Direct the Member to submit such evidence to the IRE; and

iii. Include information regarding how the Member may contact the IRE.

D. Standard Pre-Service Appeal Processing

1. Upon receipt of a request for Appeal, GARS staff shall:

a. Date stamp, and code the request with ~~one (1) or more Reason Codes~~the appropriate categorization in the database; and

b. Prepare a case file that contains the original request for Appeal, notice of ~~the~~CalOptima's or the Health Network's adverse Organization Determination, and all other correspondence.

~~2.~~ If a Member makes a verbal ~~Complaint, in accordance with CalOptima Policy MA.9001: Complaint Process, and GARS staff classifies such Complaint as an~~ Appeal,

~~3.~~2. GARS staff shall request confirmation of such Appeal as follows:

a. GARS staff shall confirm with the party receiving the verbal ~~Complaint~~Appeal that he or she verified with the ~~Member, his or her Authorized Representative, or the treating physician~~Appealing Party the facts and basis of the request for Appeal. The validated verbal acknowledgment shall be documented in the CalOptima database.

b. GARS staff shall send an Acknowledgement Letter for verbal Appeal requests to the Member to confirm the facts and basis of the Appeal to ensure the request is properly and accurately noted and addressed by CalOptima. Notice should advise the Member to contact CalOptima if the Acknowledgement Letter does not correctly capture the Member's request.

~~4.~~3. GARS staff shall verify that the request meets criteria for processing as an Appeal:

a. GARS staff shall verify that the requestor is a Member, the Member's Authorized Representative, ~~or~~ treating physician. acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician. If the requestor is not ~~the Member, the Member's Authorized Representative, or treating physician~~one of these parties, GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Member's Authorized Representative. Included with the request, staff shall send an Appointment of Representative Form, and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for an Appeal determination.

i. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, GARS staff shall make and document ~~as~~at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

ii. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative within thirty (30) calendar days or no later forty-four (44) calendar days if CalOptima extended the timeframe, after CalOptima's receipt of the Appeal~~,~~:

1) CalOptima shall dismiss the Appeal and notify the Member, in writing, that the request for Appeal shall be dismissed due to lack of the required documentation to process the request~~.~~ using the Notice of Dismissal of Appeal Request.

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a) The dismissal would be no sooner than thirty (30) calendar days and no later than an additional fourteen (14) calendar days when an extension is granted.

~~a)~~b) The dismissal notice shall inform the Member of the process and his or her right to request a review of the dismissal by an ~~Independent Review Entity (IRE).~~IRE, and that such a request must be filed within sixty (60) calendar days from the date of receipt of CalOptima's written dismissal notice.

b. GARS staff shall verify that CalOptima or a Health Network denied a service. If CalOptima~~,~~ or a Health Network~~,~~ did not deny a service, GARS staff shall contact the ~~Member, the Member's Authorized Representative, or treating physician~~Appealing Party to determine the purpose of the request for Appeal.

c. GARS staff shall review the notice of adverse Organization Determination to verify that CalOptima received the request for Appeal within sixty ~~five (65~~ (60) days after the date of notice. If CalOptima received the request later than sixty ~~five (65~~ (60) days after the date of notice, GARS staff shall provide the over sixty (60) day letter to the ~~Member, his or her Authorized Representative, or treating physician~~Appealing Party, indicating that the request does not meet criteria for Appeal unless the ~~requesting party~~Appealing Party provides good cause for an extension, in accordance with Section III.B.1.b. of this ~~policy~~Policy.

d. If CalOptima determines a Member's Appeal was misclassified as a Grievance and later discovers the error, CalOptima shall notify the Member, in writing, of the misclassified Appeal, and immediately process the reclassified Appeal through the Appeal process in accordance with this Policy. CalOptima shall consider the date of receipt of the original request as the date of receipt of the Appeal and not the date the misclassification was discovered.

e. If CalOptima identifies that the Member has obtained the service before CalOptima completes its Appeal determination, CalOptima shall dismiss the Appeal request.

i. CalOptima shall send a written Notice of Dismissal of Appeal Request form to the Member or Member's Authorized Representative at their last known address at the conclusion of the applicable adjudication timeframe.

ii. The dismissal is not considered an adverse determination; however, the dismissal notice must state the reason for the dismissal and explain the Member's right to request IRE review of the dismissal, which must be filed within sixty (60) calendar days from the date of receipt of CalOptima's written dismissal notice.

f. CalOptima's dismissal of an Appeal request shall be binding unless:

i. The Member or other Appealing party requests review by the IRE or the dismissal is vacated under the applicable regulation.

ii. The Appeal is modified or reversed by CalOptima, as applicable, upon reconsideration or vacated.

iii. A party meets the amount in controversy threshold requirements necessary for the right to a review by an Administrative Law Judge (ALJ) or attorney adjudicator and the party files a proper request for review with the Office of Medicare Hearings and Appeals.

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g. If CalOptima or the IRE establish good cause for vacating an issued dismissal of an Appeal within six (6) months of the date of the dismissal, the dismissal may be vacated.

4. If GARS staff identifies a potential quality of care issue, he or she shall refer the issue to the Quality Improvement (QI) Department, in accordance with quality of care Grievance procedures within CalOptima Policy MA.9002: Member Grievance Process.

~~1. Upon verification that the request meets criteria for processing as an Appeal, GARS staff shall send an Acknowledgment Letter, an Authorization for Use and Disclosure of Protected Health Information, and a self-addressed stamped envelope to the Member, the Member's Authorized Representative, or treating physician who submitted the request for Appeal within five (5) business days after CalOptima receives such request.~~

5. GARS staff shall prepare the case file with appropriate information and documents that include, but are not limited to, the following:

a. The case file for all Appeals which shall include:

i. A copy of the Member's eligibility status; and

ii. A copy of the ~~Member's, his or her Authorized Representative's, or treating physician's~~Appealing Party's request for Appeal.

b. If the Appeal involves non-coverage of a hospital or Skilled Nursing Facility (SNF) stay, the case file shall include:

i. A copy of the Member's Medical Records from the corresponding hospital, or SNF;

ii. A copy of utilization records related to admission and discharge; and

iii. A copy of a signed non-coverage letter to the Member, or his or her Authorized Representative, or a copy of the certified mail receipt.

c. If the Appeal involves non-coverage of home health care, the case file shall include:

i. A copy of the Member's home health records;

ii. A copy of the Member's Medical Records from the Member's physician; and

iii. A copy of the Member's discharge notification.

d. If the Appeal involves a pre-service denial or non-authorization, the case file shall include:

i. A copy of all records considered at the time of denial;

ii. A copy of the notice of Organization Determination; and

iii. Any additional Medical Records mentioned by the Member, or Provider.

e. If the Appeal involves a Covered Service that does not meet criteria, the case file shall include:

i. A copy of all records considered at the time of denial; and

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ii. A copy of the notice of Organization Determination.

6. GARS staff shall request necessary Medical Records using an Authorization for Use and Disclosure of Protected Health Information Form, an Appeal Information Request Form~~,~~ or Medical Records Request Form.

   a. GARS staff may request a Member's Medical Records from any Provider by submitting an Authorization for Use and Disclosure of Protected Health Information Form to such Provider by facsimile labeled with "MEMBER SIGNATURE ON FILE," which shall suffice to obtain records for a Member.

   b. If a Provider fails to respond to a request for a Member's Medical Records within five (5) calendar days after such request, GARS staff shall notify the Provider Relations Department. If the Provider Relations Department is unable to obtain the Member's Medical Records within five (5) calendar days, the GARS staff shall present the Appeal to the Medical Director without such Medical Records.

   c. If CalOptima cannot obtain all relevant documentation, it shall make a decision based on the material available.

8. Upon verification that the request meets criteria for processing as an Appeal, GARS staff shall send an Acknowledgment Letter, an Authorization for Use and Disclosure of Protected Health Information, and a self-addressed stamped envelope to the Appealing Party who submitted the request for Appeal within five (5) business days after CalOptima receives such request.

E. Standard Pre-Service Appeal Determination

1. CalOptima shall designate an individual, other than the person involved in making the initial Organization Determination, to review a request for Appeal.

   a. If CalOptima based the original denial on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

   b. If the request for Appeal involves emergency services, CalOptima shall apply the prudent layperson standard when making the Appeal determination.

2. GARS staff shall present the Appeal to the designated reviewer for decision.

3. GARS staff shall document the decision and the rationale for the decision in CalOptima's database.

4. If, upon Appeal, CalOptima completely reverses its adverse Organization Determination, GARS staff shall:

   a. Notify the Appealing Party and all involved parties of the decision, verbally, no later than one (1) business day from the decision date.

   ~~a.~~b. Notify the Member of the decision ~~verbally and~~ , in writing, no later than three (3) calendar days of the verbal notice.

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~~b.~~c. Coordinate with the CalOptima's Utilization Management (UM) Department or the Member's Health Network to authorize or provide the disputed service ~~within~~ no later than thirty (30) calendar days or within forty-four (44) calendar days if an extension has been requested after CalOptima's receipt of the request for Appeal;

~~c.~~d. Notify the Member's requesting Provider of CalOptima's decision.

~~d.~~e. Ensure that the Member's case file includes documentation of the authorization~~,~~ or provision; and

~~e.~~f. Note the Appeal as "closed" in the Appeals database.

5. If, upon Appeal, CalOptima affirms, in whole or in part, the adverse Organization Determination, CalOptima shall take the following actions:

   a. GARS staff shall notify the ~~Member, or his or her Authorized Representative, or treating physician~~Appealing Party of CalOptima's decision, verbally, within one (1) business day after CalOptima makes the Appeal determination, but not later than thirty (30) calendar days after receipt of the request for Appeal, or within forty-four (44) calendar days if an extension has been requested after receipt of the request for Appeal, ~~including notice that CalOptima forwarded the Appeal to the IRE;~~and notify the Appealing Party, in writing, within three (3) calendar days of the verbal notice. GARS will notify the Member upon forwarding the case to the IRE of the following by using the model Notice of Appeal Status:

      i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

      ii. Direct the Member to submit such evidence to the IRE; and

      iii. Include information regarding how the Member may contact the IRE.

   b. GARS staff shall mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file~~, the Reconsideration Background Data Form, Case Narrative and the Appeal decision letter to the IRE within five (5) calendar days of~~ to the IRE, following receipt of CalOptima's Appeal determination~~, or within~~ as follows:

   ~~b.~~ Standard Pre-Service Appeal: As expeditiously as the Member's health condition requires, or no later than thirty (30) calendar days after receipt of the request for Appeal, ~~whichever is less.~~

      i. ~~Within~~ or within forty-four (~~4) weeks~~44) calendar days if an extension has been requested after ~~CalOptima submits~~receipt of the request; or

      ii. Part B Drug Appeals: Within twenty-four (24) hours of CalOptima's Appeal determination.

      iii. If GARS staff is unable to upload the case files (Standard Pre-Service Appeal or Part B Drug Appeal) through the IRE QIC Appeals Portal, GARS staff shall submit such case files to the IRE by overnight mail/next day delivery, within twenty-four (24) hours after the decision is rendered.

      iv. The following should be included in the case file forwarded to the IRE:

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1) Appeal Case File Cover Sheet;

2) Reconsideration Background Date Form (not required if submitting via IRE web portal);

3) Case Narrative;

4) Copy of the initial Adverse Organization Determination Request and Notice;

5) Copy of the Appeal Request and Notice;

6) Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Member, provider, and/or prescriber);

7) Representation documentation for representative Appeals;

8) A complete copy of the relevant EOC on a compact disc (CD) (if file is not submitted via IRE web portal); and

9) Dismissal Case File Data Form.

c. Within ten (10) business days of CalOptima's case file submission of a standard Pre-Service Appeal to the IRE, the GARS Manager, or his or her designee, shall review ~~the~~such case file to determine if CalOptima received an IRE Acknowledgment Letter to Member. If CalOptima did not receive such ~~Acknowledgement Letter~~a letter, GARS staff shall send a letter to the IRE requesting acknowledgment of receipt of the case file, using the CalOptima Letter to IRE for acknowledgement of receipt upon identifying no receipt of the IRE Acknowledgement Letter from the IRE.

6. Upon ~~a Member's~~an Appealing Party's request, CalOptima shall provide the ~~Member~~Appealing Party with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and other pertinent information used to support CalOptima's decision. CalOptima shall provide records at no cost.

F. IRE Determination

1. The IRE will make a decision on an Appeal as quickly as the Member's health requires, but no later than its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima within a specified timeframe, using the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Cover Sheet and Request for Information Response Letter to IRE.

3. If the IRE upholds CalOptima's adverse Organization Determination, it will notify CalOptima and the Member of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Member's Appeal file and update the Appeal tracking system.

4. If the IRE reverses or partially reverses CalOptima's adverse Organization Determination, GARS staff shall:

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a. Send a ~~notice~~Notice of ~~compliance~~Compliance letter to the Member;

b. Notify the Member's Provider of the IRE's decision;

c. Coordinate with CalOptima's Utilization Management Department, or the Member's Health Network, to:

i. Provide the disputed service as soon as medically indicated, but not later than fourteen (14) calendar days after notice of such reversal from the IRE; or

ii. Authorize the disputed service within seventy-two (72) hours after notice of such reversal from the IRE.

d. Send a notice of compliance to the IRE using the Statement of Compliance Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

e. Document all activities in the Appeal tracking system.

G. Administrative Law Judge (ALJ) Hearing

1. ~~A Member, or his or her Authorized Representative,~~An Appealing Party has the right to a hearing before an ALJ if the projected value of the disputed service is within the threshold amount set by CMS.

2. ~~A Member, or a Member's Authorized Representative,~~An Appealing Party shall request an ALJ hearing by submitting, such request:

a. In writing to CalOptima, or to the IRE; and

b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. ~~The Member, or the Member's Authorized Representative,~~The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Member~~,~~ or the Member's Authorized Representative~~,~~ cannot meet the timeframe, in accordance with Title 20, Code of Federal Regulations, ~~Sections~~section 404.911.

3. If CalOptima receives a request for an ALJ hearing from ~~a Member, or his or her Authorized Representative,~~an Appealing Party GARS staff shall forward the request to the IRE. The IRE will compile and forward the Member's file to the ALJ.

4. CalOptima shall not have the right to request an ALJ hearing, but shall remain a party to the hearing.

5. If the ALJ reverses CalOptima's adverse Organization Determination, in whole or in part, CalOptima shall:

a. Authorize~~,~~ or provide~~,~~ the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the ALJ reversing the determination, unless CalOptima requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.~~I~~J. of this ~~policy~~Policy. If CalOptima requests a MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

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b. Inform the IRE, in writing, when it effectuates the decision.

H. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC review of the ALJ decision or dismissal.

2. A party requesting a MAC review shall submit such request:

   a. In writing, directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima receives ~~a Member's, or a Member's Authorized Representative's,~~an Appealing Party's request for a MAC review, it shall forward a copy of the Member's request for MAC review, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima requests a MAC Review, it shall:

   a. Submit a written request to the MAC;

   b. Concurrently notify the Member of CalOptima's request by sending the Member a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its own motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties in writing of its decision to initiate such review.

6. If the MAC reverses CalOptima's adverse Organization Determination, in whole or in part, CalOptima shall:

   a. Authorize, or provide, the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the MAC reversing the adverse Organization Determination; and

   b. Inform the IRE, in writing, when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima, may request a judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

   b. The amount in controversy meets the CMS designated amount for judicial review.

2. Any party, including CalOptima, may request a judicial review of a MAC decision if:

   a. The MAC denied the party's request for review; or

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b. It is the final decision of CMS; and

c. The amount in controversy meets the CMS designated amount for judicial reviews.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima shall notify all other parties to an Appeal prior to requesting judicial review.

6. If the judicial review reverses CalOptima's adverse Organization Determination, in whole or in part, CalOptima shall:

a. Authorize~~,~~ or provide~~,~~ the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and

b. Inform the IRE, in writing, when it effectuates the decision.

J. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources including, but not limited to, Grievances, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Board of Directors with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable
~~A. Written Appeal Acknowledgment Letter~~
~~B. Verbal Appeal Acknowledgement~~
~~C. Verbal Summary~~
~~D. Appointment of Representative Form~~
~~E. Authorization for Release of Protected Health Information (PHI)~~
~~F. Instruction Sheet for HIPAA Authorization for Release of Protected Health Information~~
~~G. Member Appeal Information Request~~
~~H. Appeal Received After 60 Days Letter~~
~~I. Reconsideration Background Data Form~~
~~J. Case Narrative Form~~
~~K. Notice to Member of Favorable Outcome~~
~~L. Notice to Member of Unfavorable Outcome~~
~~M. Notice of Appeal Status~~

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy HH.1104: Complaints of Discrimination.
C. CalOptima Policy MA.4002: Cultural and Linguistic Services

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~~C.~~D. CalOptima Policy MA.9001: Complaint Process
~~D.~~E. CalOptima Policy MA.9002: Member Grievance Process
~~E.~~F. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
G. "CalOptima Policy MA.9005: Payment Appeal
H. CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes
~~F.~~I. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures~~," Health Plan Management System (HPMS) Memorandum, Issued 09/10/2013~~
J. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
K. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
~~G.~~L. Medicare Managed Care Manual, Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs)
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
~~H.~~N. Reason Codes
~~I.~~O. Social Security Act, §205(g)
~~J.~~P. Title 20, Code of Federal Regulations (C.F.R.), §404.911
~~K.~~Q. Title 42, Code of Federal Regulations (C.F.R.), §422.113(b)(1)(i), §422.560 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.9003	Standard Service Appeal	OneCare
Revised	07/01/2007	MA.9003	Standard Service Appeal	OneCare
Revised	04/01/2009	MA.9003	Standard Service Appeal	OneCare
Revised	10/01/2012	MA.9003	Standard Service Appeal	OneCare
Revised	12/01/2016	MA.9003	Standard Appeal	OneCare
Revised	05/01/2017	MA.9003	Standard Appeal	OneCare
Revised	04/01/2022	MA.9003	Standard Pre-Service Appeal	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse initial organization determination made by CalOptima on ~~the~~ health care services ~~a member~~or benefits under Part C the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services ~~(such that~~or drug coverage (when a delay would adversely affect the health of the member), or on any amounts the ~~member~~Member must pay for a service~~.~~ or drug as defined in CFR §422.566(b) and §423.566(b). These procedures include reconsideration by ~~CalOptima and if necessary,~~ an independent review entity~~, hearings before~~ (IRE), adjudication by an Administrative Law Judges (ALJs),or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.
~~Authorized Representative~~Appealing Party	~~Any individual authorized by a Member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual.~~For purposes of this Policy, a Member, a Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician.
Authorized Representative~~Complaint~~	~~Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may include concerns about the operations of Providers or CalOptima such as waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.~~ 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. 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. The Authorized Representative will have all of the rights and responsibilities or an enrollee or other party, as applicable.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

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Term	Definition
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review Medicare health plans' ~~adverse appeal decisions.~~denial of Coverage Determinations.
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.
Member	~~An enrollee~~ A beneficiary ~~of the~~enrolled in a CalOptima ~~OneCare~~ program.
Medical Record	A medical records, 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.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, ~~Physician Medical Group~~Health Network, or other person or institution who furnishes Covered Services.
Organization Determination	Any determination made by CalOptima with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima. 3. CalOptima's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima; 4. Reduction or premature discontinuation of a previously authorized service; or 5. CalOptima's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Pre-Service	Review of any case or service that requires approval by OneCare or a Health Network, in whole or in part, in advance of the Member obtaining medical care or services. Pre-authorization and precertification are pre-service decisions.
Quality Improvement Committee (QIC)	CalOptima committee that is responsible for the Quality Improvement (QI) process.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.

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Policy:	MA.9003
Title:	**Standard Pre-Service Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy addresses Medicare Part C Appeals and describes the process by which CalOptima ensures that Members have clear and reliable access to a standard Appeal process for Pre-Service Organization Determinations, consistent with the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima shall establish and maintain a process that addresses the receipt, handling, and disposition of a Part C Appeal, in accordance with applicable statutes, regulations, contractual requirements, and this Policy.

B. Grievance and Appeals Resolution Services (GARS) staff shall accept, track, and report all Appeals.

C. Subject to the provisions of this Policy, an Appealing Party has the right to request an Appeal of a Pre-Service Organization Determination.

D. A Member shall have the right to an attorney, or other representation, in the Appeal process.

E. Subject to the provisions of this Policy, CalOptima shall process an Appeal within thirty (30) calendar days after receipt of the Appeal.

F. The processing timeframe for a standard Appeal shall begin when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives an Appeal request.

G. Subject to the provisions of this Policy, CalOptima shall process an Appeal involving Part B drugs within seven (7) calendar days after receipt of such Appeal type.

H. If the Appealing Party believes that CalOptima's thirty (30) calendar day Appeal process may seriously jeopardize the Member's life, health, or ability to regain maximum function, the Member, the Member's Authorized Representative, or physician may request an expedited Appeal, in accordance with CalOptima Policy MA.9004: Expedited Pre-Service Appeal.

Back To Item Back to Agenda

I. CalOptima shall notify a Member of the Appeal process:

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage (EOC) and periodic Member newsletters;

3. In all notices of adverse Organization Determination;

4. Upon involuntary disenrollment; and

5. Upon the Member's request.

J. Upon request, CalOptima shall provide a Member with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and information used to support CalOptima's decision.

K. All CalOptima departments shall respond promptly, within the designated timeframes, to any inquiry related to an Appeal.

L. CalOptima shall provide all parties to an Appeal with reasonable opportunity to present evidence, or allegations of fact or law, related to the issue in dispute, in person, or in writing. CalOptima shall take all evidence into account when making its decision.

M. CalOptima shall ensure that its Health Networks direct a Member to CalOptima GARS if the Member requests an Appeal of a CalOptima or Health Network decision.

N. CalOptima shall ensure that there is no discrimination against a Member on the grounds that such Member filed an Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

O. CalOptima shall ensure that Members have equal access to, and can fully participate in, the Appeal process by providing assistance to Members with limited English proficiency, vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

P. If an Appeal involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

R. Non-contracted Provider Appeal requests related to claim disputes shall be processed in accordance with CalOptima Policy MA.9009: Non-Contract Provider Payment Disputes.

S. If an Appeal involves an Organization Determination regarding payment for services rendered to a Member, CalOptima shall process such Appeal in accordance with CalOptima Policy MA.9005: Payment Appeal.

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T. Any potential quality of care issues shall be referred to the Quality Improvement (QI) Department in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

III. PROCEDURE

A. Parties to a Standard Pre-Service Appeal

1. A Member or an individual appointed by the Member (e.g., relative, friend, advocate, attorney) acting as the Member's Authorized Representative may file an Appeal. If an Authorized Representative files an Appeal, he or she shall submit documentation of such appointment, as follows:

   a. Appropriate legal documents, or authority, supporting such appointment; or

   b. Appointment of Representative Form or equivalent written notice (Representative Form) signed by both the Member and the Member's Authorized Representative, except if an attorney acts as the Member's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form, or equivalent written notice, signed by the Member only.

2. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Member in filing an Appeal.

   a. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

   b. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

3. A Provider shall not charge a Member to act as the Member's Authorized Representative.

B. Request for a Standard Pre-Service Appeal

1. An Appealing Party may request an Appeal verbally, by telephone, or in person with the Customer Service Department, or in writing to CalOptima within sixty (60) calendar days from the date of the notice of the initial adverse Organization Determination.

   a. CalOptima may accept a request for an Appeal filed after the sixty (60) calendar day limit, if the Appealing Party submits a written request for an extension of the timeframe for good cause.

      i. In its request for an extension, the Appealing Party must include a statement explaining why the request for Payment Appeal was not filed on time.

      ii. If the request for an extension submitted does not include an explanation as to why the request for Payment Appeal was not filed on time, CalOptima may attempt to obtain information supporting good cause for the late filing.

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iii. In making its determination, CalOptima should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

iv. CalOptima shall ensure that there is no discrimination against a Member in the determination of good cause justification when an Appeal request is outside the sixty (60) calendar day limit, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

v. Instances where good cause may exist include, but are not limited to:

a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

b) The Appealing Party was seriously ill which prevented a timely Appeal;

c) Death or serious illness in the Appealing Party's immediate family;

d) An accident causing important records to be destroyed;

e) Difficulty in locating and/or receiving necessary documents within the established time limits;

f) Incomplete or incorrect information regarding the Appeal process;

g) The Appealing Party's lack of capacity to understand the Appeal filing timeframe;

h) The Appealing Party sent the request to an incorrect address, in good faith, within the established time limit; or

i) The delay resulted from additional time required to produce Member documents in an accessible format pursuant to CalOptima Policy MA.4002: Cultural and Linguistic Services.

j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program or a senior center), on account of his or her disability, in order to be able to file the Appeal.

vi. If CalOptima denies the Appealing Party's request for good cause extension, CalOptima must dismiss such request and the Appealing Party may file a Grievance in accordance with CalOptima Policy MA.9002: Member Grievance Process.

2. An Appeal request shall be considered received on the date and time:

a. When any department within CalOptima initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima (or its designee);

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c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

f. An Appeal request is received through CalOptima's website.

3. An Appealing Party may withdraw the request at any time before CalOptima renders a decision by notifying CalOptima of such withdrawal verbally or in writing.

a. If that party withdraws the Appeal request verbally, CalOptima shall mail the party a written confirmation of the withdrawal within three (3) calendar days from the date of the verbal request.

b. If the withdrawal request is received after CalOptima has forwarded the case file to the Independent Review Entity (IRE), then CalOptima must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima or a delegated entity not responsible for processing Appeals that incorrectly receives an Appeal request, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

5. An Appealing Party may request an expedited Appeal, in accordance with CalOptima Policy MA.9004: Expedited Pre-Service Appeal.

C. Standard Pre-Service Appeal Timeframe

1. Subject to the provisions of this Policy, CalOptima shall make an Appeal determination, as expeditiously as the Member's case requires, based on the Member's health status, but not later than thirty (30) calendar days upon receipt of a request for an Appeal for items and services, unless a fourteen (14) calendar day extension has been granted. Part B drug timeframes cannot be extended.

a. The Appeal processing timeframe begins when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives an Appeal request. If such CalOptima unit or delegated entity incorrectly receives an Appeal request, the party shall handle that request in accordance with Section III.B.4. of this Policy.

b. If CalOptima obtains information establishing good cause, the adjudication timeframe of the Appeal request begins on the date CalOptima receives that information.

c. CalOptima shall inform the Member or Member's Authorized Representative of the right to request a fourteen (14) calendar day extension if additional time is needed to submit evidence related to an Appeal.

2. CalOptima may extend the timeframe for an Appeal determination for items and services up to fourteen (14) calendar days upon the Member's request (except for Part B drugs), or if CalOptima needs additional information to make a determination, and such extension is

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justified and in the Member's interest due to the need for additional medical evidence from a non-contracted Provider that may change CalOptima's decision to deny an item or service, or it is the Member's best interest due to extraordinary, exigent, or other non-routine circumstances, such as a natural disaster. If CalOptima extends the timeframe for an Appeal determination, it shall provide the Member with written notice that includes:

a. The reason for the extension; and

b. The Member's right to file an expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process, if he or she disagrees with CalOptima's decision to extend the timeframe.

3. Subject to the provisions of this Policy, CalOptima shall make an Appeal determination for Part B drugs, as expeditiously as the Member's case requires, based on the Member's health status, but not later than seven (7) calendar days after receipt of a request for such Appeal type. Part B drug timeframes cannot be extended.

4. If CalOptima fails to provide an Appealing Party with an Appeal determination within the timeframes specified in Sections III.C.1.-3. of this Policy:

a. CalOptima shall consider such failure as an affirmation of the adverse Organization Determination; and

b. CalOptima shall forward the complete case file of the Appeal request to the IRE no later than thirty (30) calendar days after receiving the request for Appeal, or no later than forty-four (44) calendar days if CalOptima extended the timeframe, in accordance with Section III.E.5.b.. of this Policy.

c. CalOptima GARS will notify the Appealing Party who requested the Appeal, in writing, that CalOptima forwarded the request to the IRE for final determination by using the model Notice of Appeal Status:

i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

ii. Direct the Member to submit such evidence to the IRE; and

iii. Include information regarding how the Member may contact the IRE.

D. Standard Pre-Service Appeal Processing

1. Upon receipt of a request for Appeal, GARS staff shall:

a. Date stamp, and code the request with the appropriate categorization in the database; and

b. Prepare a case file that contains the original request for Appeal, notice of CalOptima's or the Health Network's adverse Organization Determination, and all other correspondence.

2. If a Member makes a verbal Appeal, GARS staff shall request confirmation of such Appeal as follows:

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a. GARS staff shall confirm with the party receiving the verbal Appeal that he or she verified with the Appealing Party the facts and basis of the request for Appeal. The validated verbal acknowledgment shall be documented in the CalOptima database.

b. GARS staff shall send an Acknowledgement Letter for verbal Appeal requests to the Member to confirm the facts and basis of the Appeal to ensure the request is properly and accurately noted and addressed by CalOptima. Notice should advise the Member to contact CalOptima if the Acknowledgement Letter does not correctly capture the Member's request.

3. GARS staff shall verify that the request meets criteria for processing as an Appeal:

a. GARS staff shall verify that the requestor is a Member, the Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician. If the requestor is not one of these parties, GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Member's Authorized Representative. Included with the request, staff shall send an Appointment of Representative Form, and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for an Appeal determination.

i. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, GARS staff shall make and document at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

ii. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative within thirty (30) calendar days or no later forty-four (44) calendar days if CalOptima extended the timeframe, after CalOptima's receipt of the Appeal:

1) CalOptima shall dismiss the Appeal and notify the Member, in writing, that the request for Appeal shall be dismissed due to lack of the required documentation to process the request using the Notice of Dismissal of Appeal Request.

a) The dismissal would be no sooner than thirty (30) calendar days and no later than an additional fourteen (14) calendar days when an extension is granted.

b) The dismissal notice shall inform the Member of the process and his or her right to request a review of the dismissal by an IRE, and that such a request must be filed within sixty (60) calendar days from the date of receipt of CalOptima's written dismissal notice.

b. GARS staff shall verify that CalOptima or a Health Network denied a service. If CalOptima or a Health Network did not deny a service, GARS staff shall contact the Appealing Party to determine the purpose of the request for Appeal.

c. GARS staff shall review the notice of adverse Organization Determination to verify that CalOptima received the request for Appeal within sixty (60) days after the date of notice. If CalOptima received the request later than sixty (60) days after the date of notice, GARS staff shall provide the over sixty (60) day letter to the Appealing Party, indicating that the request does not meet criteria for Appeal unless the Appealing Party provides good cause for an extension, in accordance with Section III.B.1.b. of this Policy.

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d. If CalOptima determines a Member's Appeal was misclassified as a Grievance and later discovers the error, CalOptima shall notify the Member, in writing, of the misclassified Appeal, and immediately process the reclassified Appeal through the Appeal process in accordance with this Policy. CalOptima shall consider the date of receipt of the original request as the date of receipt of the Appeal and not the date the misclassification was discovered.

e. If CalOptima identifies that the Member has obtained the service before CalOptima completes its Appeal determination, CalOptima shall dismiss the Appeal request.

i. CalOptima shall send a written Notice of Dismissal of Appeal Request form to the Member or Member's Authorized Representative at their last known address at the conclusion of the applicable adjudication timeframe.

ii. The dismissal is not considered an adverse determination; however, the dismissal notice must state the reason for the dismissal and explain the Member's right to request IRE review of the dismissal, which must be filed within sixty (60) calendar days from the date of receipt of CalOptima's written dismissal notice.

f. CalOptima's dismissal of an Appeal request shall be binding unless:

i. The Member or other Appealing party requests review by the IRE or the dismissal is vacated under the applicable regulation.

ii. The Appeal is modified or reversed by CalOptima, as applicable, upon reconsideration or vacated.

iii. A party meets the amount in controversy threshold requirements necessary for the right to a review by an Administrative Law Judge (ALJ) or attorney adjudicator and the party files a proper request for review with the Office of Medicare Hearings and Appeals.

g. If CalOptima or the IRE establish good cause for vacating an issued dismissal of an Appeal within six (6) months of the date of the dismissal, the dismissal may be vacated.

4. If GARS staff identifies a potential quality of care issue, he or she shall refer the issue to the Quality Improvement (QI) Department, in accordance with quality of care Grievance procedures within CalOptima Policy MA.9002: Member Grievance Process.

5. GARS staff shall prepare the case file with appropriate information and documents that include, but are not limited to, the following:

a. The case file for all Appeals which shall include:

i. A copy of the Member's eligibility status; and

ii. A copy of the Appealing Party's request for Appeal.

b. If the Appeal involves non-coverage of a hospital or Skilled Nursing Facility (SNF) stay, the case file shall include:

i. A copy of the Member's Medical Records from the corresponding hospital, or SNF;

ii. A copy of utilization records related to admission and discharge; and

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iii. A copy of a signed non-coverage letter to the Member, or his or her Authorized Representative, or a copy of the certified mail receipt.

c. If the Appeal involves non-coverage of home health care, the case file shall include:

i. A copy of the Member's home health records;

ii. A copy of the Member's Medical Records from the Member's physician; and

iii. A copy of the Member's discharge notification.

d. If the Appeal involves a pre-service denial or non-authorization, the case file shall include:

i. A copy of all records considered at the time of denial;

ii. A copy of the notice of Organization Determination; and

iii. Any additional Medical Records mentioned by the Member, or Provider.

e. If the Appeal involves a Covered Service that does not meet criteria, the case file shall include:

i. A copy of all records considered at the time of denial; and

ii. A copy of the notice of Organization Determination.

6. GARS staff shall request necessary Medical Records using an Authorization for Use and Disclosure of Protected Health Information Form, an Appeal Information Request Form or Medical Records Request Form.

a. GARS staff may request a Member's Medical Records from any Provider by submitting an Authorization for Use and Disclosure of Protected Health Information Form to such Provider by facsimile labeled with "MEMBER SIGNATURE ON FILE," which shall suffice to obtain records for a Member.

b. If a Provider fails to respond to a request for a Member's Medical Records within five (5) calendar days after such request, GARS staff shall notify the Provider Relations Department. If the Provider Relations Department is unable to obtain the Member's Medical Records within five (5) calendar days, the GARS staff shall present the Appeal to the Medical Director without such Medical Records.

c. If CalOptima cannot obtain all relevant documentation, it shall make a decision based on the material available.

8. Upon verification that the request meets criteria for processing as an Appeal, GARS staff shall send an Acknowledgment Letter, an Authorization for Use and Disclosure of Protected Health Information, and a self-addressed stamped envelope to the Appealing Party who submitted the request for Appeal within five (5) business days after CalOptima receives such request.

E. Standard Pre-Service Appeal Determination

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1. CalOptima shall designate an individual, other than the person involved in making the initial Organization Determination, to review a request for Appeal.

    a. If CalOptima based the original denial on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

    b. If the request for Appeal involves emergency services, CalOptima shall apply the prudent layperson standard when making the Appeal determination.

2. GARS staff shall present the Appeal to the designated reviewer for decision.

3. GARS staff shall document the decision and the rationale for the decision in CalOptima's database.

4. If, upon Appeal, CalOptima completely reverses its adverse Organization Determination, GARS staff shall:

    a. Notify the Appealing Party and all involved parties of the decision, verbally, no later than one (1) business day from the decision date.

    b. Notify the Member of the decision, in writing, no later than three (3) calendar days of the verbal notice.

    c. Coordinate with the CalOptima's Utilization Management (UM) Department or the Member's Health Network to authorize or provide the disputed service no later than thirty (30) calendar days or within forty-four (44) calendar days if an extension has been requested after CalOptima's receipt of the request for Appeal;

    d. Notify the Member's requesting Provider of CalOptima's decision.

    e. Ensure that the Member's case file includes documentation of the authorization or provision; and

    f. Note the Appeal as "closed" in the Appeals database.

5. If, upon Appeal, CalOptima affirms, in whole or in part, the adverse Organization Determination, CalOptima shall take the following actions:

    a. GARS staff shall notify the Appealing Party of CalOptima's decision, verbally, within one (1) business day after CalOptima makes the Appeal determination, but not later than thirty (30) calendar days after receipt of the request for Appeal, or within forty-four (44) calendar days if an extension has been requested after receipt of the request for Appeal, and notify the Appealing Party, in writing, within three (3) calendar days of the verbal notice. GARS will notify the Member upon forwarding the case to the IRE of the following by using the model Notice of Appeal Status:

        i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

        ii. Direct the Member to submit such evidence to the IRE; and

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iii. Include information regarding how the Member may contact the IRE.

b. GARS staff shall mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file to the IRE, following receipt of CalOptima's Appeal determination as follows:

i. Standard Pre-Service Appeal: As expeditiously as the Member's health condition requires, or no later than thirty (30) calendar days after receipt of the request for Appeal, or within forty-four (44) calendar days if an extension has been requested after receipt of the request; or

ii. Part B Drug Appeals: Within twenty-four (24) hours of CalOptima's Appeal determination.

iii. If GARS staff is unable to upload the case files (Standard Pre-Service Appeal or Part B Drug Appeal) through the IRE QIC Appeals Portal, GARS staff shall submit such case files to the IRE by overnight mail/next day delivery, within twenty-four (24) hours after the decision is rendered.

iv. The following should be included in the case file forwarded to the IRE:

1) Appeal Case File Cover Sheet;

2) Reconsideration Background Date Form (not required if submitting via IRE web portal);

3) Case Narrative;

4) Copy of the initial Adverse Organization Determination Request and Notice;

5) Copy of the Appeal Request and Notice;

6) Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Member, provider, and/or prescriber);

7) Representation documentation for representative Appeals;

8) A complete copy of the relevant EOC on a compact disc (CD) (if file is not submitted via IRE web portal); and

9) Dismissal Case File Data Form.

c. Within ten (10) business days of CalOptima's case file submission of a standard Pre-Service Appeal to the IRE, the GARS Manager, or his or her designee, shall review such case file to determine if CalOptima received an IRE Acknowledgment Letter to Member. If CalOptima did not receive such a letter, GARS staff shall send a letter to the IRE requesting acknowledgment of receipt of the case file, using the CalOptima Letter to IRE for acknowledgement of receipt upon identifying no receipt of the IRE Acknowledgement Letter from the IRE.

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6. Upon an Appealing Party's request, CalOptima shall provide the Appealing Party with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and other pertinent information used to support CalOptima's decision. CalOptima shall provide records at no cost.

F. IRE Determination

1. The IRE will make a decision on an Appeal as quickly as the Member's health requires, but no later than its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima within a specified timeframe, using the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Cover Sheet and Request for Information Response Letter to IRE.

3. If the IRE upholds CalOptima's adverse Organization Determination, it will notify CalOptima and the Member of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Member's Appeal file and update the Appeal tracking system.

4. If the IRE reverses or partially reverses CalOptima's adverse Organization Determination, GARS staff shall:

   a. Send a Notice of Compliance letter to the Member;

   b. Notify the Member's Provider of the IRE's decision;

   c. Coordinate with CalOptima's Utilization Management Department, or the Member's Health Network, to:

      i. Provide the disputed service as soon as medically indicated, but not later than fourteen (14) calendar days after notice of such reversal from the IRE; or

      ii. Authorize the disputed service within seventy-two (72) hours after notice of such reversal from the IRE.

   d. Send a notice of compliance to the IRE using the Statement of Compliance Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

   e. Document all activities in the Appeal tracking system.

G. Administrative Law Judge (ALJ) Hearing

1. An Appealing Party has the right to a hearing before an ALJ if the projected value of the disputed service is within the threshold amount set by CMS.

2. An Appealing Party shall request an ALJ hearing by submitting, such request:

   a. In writing to CalOptima, or to the IRE; and

   b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Member or the Member's

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Authorized Representative cannot meet the timeframe, in accordance with Title 20, Code of Federal Regulations, section 404.911.

3. If CalOptima receives a request for an ALJ hearing from an Appealing Party GARS staff shall forward the request to the IRE. The IRE will compile and forward the Member's file to the ALJ.

4. CalOptima shall not have the right to request an ALJ hearing, but shall remain a party to the hearing.

5. If the ALJ reverses CalOptima's adverse Organization Determination, in whole or in part, CalOptima shall:

   a. Authorize or provide the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the ALJ reversing the determination, unless CalOptima requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.J. of this Policy. If CalOptima requests a MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

   b. Inform the IRE, in writing, when it effectuates the decision.

H. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC review of the ALJ decision or dismissal.

2. A party requesting a MAC review shall submit such request:

   a. In writing, directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima receives an Appealing Party's request for a MAC review, it shall forward a copy of the Member's request for MAC review, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima requests a MAC Review, it shall:

   a. Submit a written request to the MAC;

   b. Concurrently notify the Member of CalOptima's request by sending the Member a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its own motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties in writing of its decision to initiate such review.

6. If the MAC reverses CalOptima's adverse Organization Determination, in whole or in part, CalOptima shall:

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a. Authorize, or provide, the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the MAC reversing the adverse Organization Determination; and

b. Inform the IRE, in writing, when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima, may request a judicial review of an ALJ decision if:

a. The MAC denied the party's request for review; and

b. The amount in controversy meets the CMS designated amount for judicial review.

2. Any party, including CalOptima, may request a judicial review of a MAC decision if:

a. The MAC denied the party's request for review; or

b. It is the final decision of CMS; and

c. The amount in controversy meets the CMS designated amount for judicial reviews.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima shall notify all other parties to an Appeal prior to requesting judicial review.

6. If the judicial review reverses CalOptima's adverse Organization Determination, in whole or in part, CalOptima shall:

a. Authorize or provide the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and

b. Inform the IRE, in writing, when it effectuates the decision.

J. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources including, but not limited to, Grievances, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Board of Directors with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy HH.1104: Complaints of Discrimination.
C. CalOptima Policy MA.4002: Cultural and Linguistic Services
D. CalOptima Policy MA.9001: Complaint Process
E. CalOptima Policy MA.9002: Member Grievance Process
F. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
G. CalOptima Policy MA.9005: Payment Appeal
H. CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes
I. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
J. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
K. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
L. Medicare Managed Care Manual, Chapter 13, Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs)
M. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
N. Reason Codes
O. Social Security Act, §205(g)
P. Title 20, Code of Federal Regulations (C.F.R.), §404.911
Q. Title 42, Code of Federal Regulations (C.F.R.), §422.113(b)(1)(i), §422.560 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.9003	Standard Service Appeal	OneCare
Revised	07/01/2007	MA.9003	Standard Service Appeal	OneCare
Revised	04/01/2009	MA.9003	Standard Service Appeal	OneCare
Revised	10/01/2012	MA.9003	Standard Service Appeal	OneCare
Revised	12/01/2016	MA.9003	Standard Appeal	OneCare
Revised	05/01/2017	MA.9003	Standard Appeal	OneCare
Revised	04/01/2022	MA.9003	Standard Pre-Service Appeal	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse initial organization determination made by CalOptima on health care services or benefits under Part C 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 CFR §422.566(b) and §423.566(b). These procedures include reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judges (ALJs),or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.
Appealing Party	For purposes of this Policy, a Member, a Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician.
Authorized Representative	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. 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. The Authorized Representative will have all of the rights and responsibilities or an enrollee or other party, as applicable.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review Medicare health plans' denial of Coverage Determinations.
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.
Member	A beneficiary enrolled in a CalOptima program.
Medical Record	A medical records, 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.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.

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Term	Definition
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.
Organization Determination	Any determination made by CalOptima with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima. 3. CalOptima's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima; 4. Reduction or premature discontinuation of a previously authorized service; or 5. CalOptima's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Pre-Service	Review of any case or service that requires approval by OneCare or a Health Network, in whole or in part, in advance of the Member obtaining medical care or services. Pre-authorization and precertification are pre-service decisions.
Quality Improvement Committee (QIC)	CalOptima committee that is responsible for the Quality Improvement (QI) process.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.

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Policy:	MA.9004
Title:	**Expedited Pre-Service Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/052005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy definesPolicy addresses Medicare Part C Appeals and describes the process by which CalOptima shall ensureensures that Members have clear and reliable access to an expedited Appeal process that meets the requirement of thefor Pre-Service Organization Determination, consistent with Centers for Medicare and& Medicaid Services (CMS).) requirements.

II. POLICY

A. If a Member, a Member's Authorized Representative, or a physicianan Appealing Party believes that CalOptima's thirty (30) calendar day standard Appeal process could seriously jeopardize the Member's life, health, or ability to regain maximum function, the Member, Authorized Representative, or physicianAppealing Party may request an expedited Appeal, in accordance with the terms and conditions of this policyPolicy.

B. CalOptima shall process an expedited Appeal within seventy-two (72) hours after receiving the request for an expedited Appeal.

C. The processing timeframe for an expedited Appeal shall begin when the appropriate department within CalOptima receives the request.

C.D. If CalOptima denies a request for an expedited Appeal, it shall process the request as a standard Appeal, in accordance with CalOptima Policy MA.9003: Standard Pre-Service Appeal.

D.E. If a physician makes, or supports, a request for an expedited Appeal, CalOptima shall grant such request, and shall process the request as an expedited Appeal.

E.F. A Member shall have the right to be represented by an attorney, or other representative, in the expedited Appeal process.

F.G. Grievance and Appeal Resolution Services (GARS) Department staff shall be responsible for tracking and reporting all expedited Appeals.

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~~G.~~H. CalOptima's Utilization Management Department shall be responsible for designating, training, and monitoring a clinical on-call nurse to accept and initiate the expedited Appeal process.

~~H.~~I. CalOptima~~,~~ or the Member's Health Network~~,~~ shall notify the Member of the expedited Appeal process:

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage and periodic Member newsletters;

3. In all notices of adverse Organization Determination and non-coverage;

4. Upon involuntary disenrollment; and

5. Upon a Member's request.

~~I. If a Member disagrees with a Provider's decision regarding a request for a service, or course of treatment, the Provider shall inform the Member of the Member's right to receive a written notice from CalOptima regarding the Member's services.~~

J. Upon request, CalOptima shall provide a Member with a copy of the contents of the Member's ~~Case File~~case file, including, but not limited to, a copy of supporting Medical Records and information used to support CalOptima's decision.

K. CalOptima shall provide all parties to an expedited Appeal with reasonable opportunity to present evidence, or allegations~~,~~ of fact or law, related to the issue in dispute, in person, or in writing. CalOptima shall take all evidence into account when making its decision.

L. If an expedited Appeal involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

~~L.~~M. CalOptima shall ensure that there is no discrimination against a Member on the grounds that such Member filed an Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

~~I. PROCEDURE~~

~~A. Request for Appeal~~

~~1. If a Member, a Member's Authorized Representative, or a physician believes that CalOptima's thirty (30) calendar day Appeal process may seriously jeopardize the Member's life, health, or ability to regain maximum function, the Member, Authorized Representative, or physician may request an expedited Appeal.~~

N. CalOptima shall ensure that Members have equal access to, and can fully participate in, the expedited Appeal process by providing assistance to Members with limited English proficiency, vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

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3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

O. If GARS staff identifies a potential quality of care issue, he or she shall refer the issue to the Quality Improvement (QI) Department, in accordance with CalOptima Policy MA.9002: Member Grievance Process.

III. PROCEDURE

A. Parties to an Expedited Pre-Service Appeal

1. An Appealing Party may file an expedited Appeal.

a. A Member ~~may appoint any~~or an individual appointed by the Member (e.g., relative, friend, advocate, attorney) as his or her Authorized Representative~~.~~ may file an expedited Appeal. If an Authorized Representative ~~requests~~files an expedited Appeal, he or she shall submit documentation of such appointment, as follows:

i. Appropriate legal documents, or authority, supporting such appointment; or

ii. Appointment of Representative Form, or ~~similar~~equivalent written ~~statement~~notice (Representative Forms) signed by both the Member and the Authorized Representative, except if an attorney acts as the Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit an Appointment of Representative Form, or ~~similar~~equivalent written ~~statement~~notice, signed by the Member only.

b. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Member in filing an expedited Appeal.

i. Authorized Representatives could include, but are not limited to, a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

ii. The Authorized Representative must produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

2. A Provider shall not charge a Member to act as the Member's Authorized Representative.

~~a. A physician, regardless of his or her contract status, may initiate an expedited Appeal.~~

~~2. A Member, an Authorized Representative, or a physician may request an expedited Appeal in writing, by telephone, or by facsimile.~~

B. ~~A Member, an Authorized Representative, or a Provider~~Request for an Expedited Pre-Service Appeal

1. If an Appealing Party believes that CalOptima's thirty (30) calendar day standard Appeal process may seriously jeopardize the Member's life, health, or ability to regain maximum function, the Appealing Party may request an expedited Appeal verbally, by telephone, or in

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person with the Customer Service Department, or in writing to CalOptima within sixty (60) calendar days from the date of the notice of the initial adverse Organization Determination.

a. CalOptima may accept a request for an expedited Appeal filed after the sixty (60) calendar day limit, if the Appealing Party submits a written request for an extension of the timeframe for good cause.

i. In its request for an extension, the Appealing Party must include a statement explaining why the request for an expedited Appeal was not filed on time.

ii. If the request for an extension submitted does not include an explanation as to why the request for an expedited Appeal was not filed on time, CalOptima may attempt to obtain information supporting good cause for the late filing.

iii. In making its determination, CalOptima should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

iv. CalOptima shall ensure that there is no discrimination against a Member in the determination of good cause justification when an expedited Appeal request is outside the sixty (60) calendar day limit, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

v. Instances where good cause may exist include, but are not limited to:

a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

b) The Appealing Party being seriously ill, which prevented a timely expedited Appeal;

c) Death or serious illness in the Appealing Party's immediate family;

d) An accident causing important records to be destroyed;

e) Difficulty in locating and/or receiving necessary documents within the established time limits;

f) Incomplete or incorrect information regarding the expedited Appeal process;

g) The Appealing Party's lack of capacity to understand the expedited Appeal filing timeframe;

h) The Appealing Party sending the request to an incorrect address, in good faith, within the established time limit;

i) The delay resulted from additional time required to produce Member documents in an accessible format pursuant to CalOptima Policy MA.4002: Cultural and Linguistic Services; or

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j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program or senior center), on account of his or her disability, in order to be able to file the expedited Appeal.

vi. If CalOptima denies the Appealing Party's request for good cause extension, CalOptima must dismiss such request and the Appealing Party may file a Grievance in accordance with CalOptima Policy MA.9002: Member Grievance Process.

2. An expedited Appeal request shall be considered received on the date and time:

a. When the appropriate department within CalOptima initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima and the appropriate department within CalOptima receives such document;

c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the expedited Appeal request or supporting statements after normal business hours); or

f. An expedited Appeal request is received through CalOptima's website.

3. An Appealing Party who requests an expedited Appeal, may withdraw such request at any time before CalOptima renders a decision by notifying CalOptima of such withdrawal verbally or in writing.

a. If that party withdraws the expedited Appeal request verbally, CalOptima shall mail that party a written confirmation of the withdrawal to the party within three (3) calendar days from the date of the verbal request.

b. If the withdrawal request is received after CalOptima has forwarded the case file to the Independent Review Entity (IRE), then CalOptima must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima or a delegated entity not responsible for processing Appeals that incorrectly receives an expedited Appeal request, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

~~B.~~C. Expedited Pre-Service Appeal Timeframe

1. Subject to the provisions of this ~~policy~~Policy, CalOptima shall make an expedited Appeal determination ~~within~~ , as expeditiously as the Member's case requires, based on the Member's health status, but not later than seventy-two (72) hours after receipt of a request for such

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expedited Appeal~~.~~ for items and services, unless a fourteen (14) calendar day extension has been granted. Part B drug timeframes cannot be extended.

a. The expedited Appeal processing timeframe begins when the appropriate CalOptima department receives an expedited Appeal request.

b. If CalOptima obtains information establishing good cause for late filing, the adjudication timeframe of the expedited Appeal request begins on the date CalOptima receives that information.

c. CalOptima shall inform the Member or Member's Authorized Representative of the right to request a fourteen (14) calendar day extension if additional time is needed to submit evidence related to an expedited Appeal.

2. CalOptima may extend the timeframe for an expedited Appeal determination for items and services by up to fourteen (14) additional calendar days upon the Member's request~~,~~ (except for Part B drugs), or if CalOptima needs additional information to make a determination, and such extension is justified and in the Member's best interest due to the need for additional medical evidence from a non-contracted Provider that may change CalOptima's decision to deny an item or service, or it is the Member's best interest due to extraordinary, exigent, or other non-routine circumstances. If CalOptima extends the timeframe for an expedited Appeal determination, it shall provide the Member with written notice that includes:

   a. The reason for the extension;

   b. The Member's right to file an Expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process, if he or she disagrees with CalOptima's decision to extend the timeframe; and

   c. Information that the Member may resubmit the request for an expedited Appeal, and that CalOptima shall expedite a request for expedited Appeal that is supported by a physician.

3. Subject to the provisions of this Policy, CalOptima shall make an expedited Appeal determination for Part B drugs, as expeditiously as the Member's case requires, based on the Member's health status, but not later than seventy-two (72) hours after receipt of a request for such Appeal type. Part B drugs timeframes cannot be extended.

~~3.~~4. If CalOptima fails to provide ~~a Member, Authorized Representative, or physician~~an Appealing Party who requests an expedited Appeal with an Appeal determination within the timeframes specified in ~~sections~~Sections III.~~B~~C.1~~ and III.B.2.~~-3. of this ~~policy~~Policy:

   a. ~~Such~~CalOptima shall consider such failure ~~shall be considered~~as an affirmation of the adverse Organization Determination;

   ~~b.~~ CalOptima shall forward the complete case file of the expedited Appeal request to the ~~Independent Review Entity (~~IRE~~); and~~

   b. no later than twenty-four (24) hours after the expedited Appeal decision, or no later than the fourteen (14) calendar day extension from receipt of the expedited Appeal request if CalOptima extended the timeframe, in accordance with Section III.E.5.b-c. of this Policy; and

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c. CalOptima GARS shall notify the ~~Member, the Authorized Representative, or the physician~~Appealing Party who requested the expedited Appeal, in writing, that CalOptima forwarded the request to the IRE for final determination~~. The notice shall~~ by using the model Notice of Appeal Status, which will:

i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

ii. Direct the Member to submit such evidence to the IRE; and

iii. Include information regarding how the Member may contact the IRE.

~~i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;~~

~~ii.~~i. ~~Direct the Member to submit such evidence to the IRE; and~~

~~iii.~~i.~~Include information regarding how the Member may contact the IRE.~~

~~C.~~D. Expedited Pre-Service Appeal Processing

1. CalOptima shall route a request for ~~Expedited~~an expedited Service Appeal as follows:

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~~Contact Type~~	~~Monday – Friday 08:00 – 17:30~~	~~Evening 17:31 – 07:59~~	~~Weekends Friday 17:31 – Monday 07:59~~	~~Holidays 24 hrs./day~~
Contact Type	Monday–Friday **08:00–17:30**	Evenings **17:31–07:59**	Weekends **Friday 17:31–Monday 07:59**	Holidays **24 hrs/day**
Telephone	Route to GARS	On-call answering service directs call to the on-call nurse	On-call answering service directs call to the on-call nurse	On-call answering service directs call to the on-call nurse
Facsimile	Take to GARS immediately	N/A	N/A	N/A

2. A ~~Grievance and Appeal Resolution Services (~~GARS~~)~~ staff member shall administer each request for expedited Appeal. ~~An on-call nurse shall initiate the processing of a request for expedited Appeal~~

~~2.~~3. For expedited Appeals received by CalOptima after hours during the evening, or on weekends, or holidays~~.~~ an on-call nurse shall initiate the process for such Appeal request by:

a. Forwarding notice of CalOptima's or the Health Network's adverse Organization Determination and the Member's Medical Records to CalOptima's on-call Medical Director for clinical review, to determine whether such request meets medical criteria for an expedited Appeal.

b. Notifying the Appealing Party verbally, whether request meets medical criteria for an expedited Appeal.

i. If request does not meet criteria, the Appeal shall be processed in accordance with Sections III.D.7.a-c. of this Policy.

ii. If the request meets criteria, CalOptima's on-call Medical Director shall make a determination, as expeditiously as the Member's case requires, but no later than seventy-two (72) hours after receipt of a request for such expedited Appeal.

~~3.~~4. Upon receipt of a request for Appeal, GARS staff shall:

a. Date stamp~~,~~ and code the request with the appropriate categorization in the database; and

b. Prepare a case file that contains the original request for expedited Appeal, notice of CalOptima's~~,~~ or the Health Network's~~,~~ adverse Organization Determination, and all other correspondence.

5. ~~Staff~~If a Member makes a verbal expedited Appeal, GARS staff shall request confirmation of such Appeal as follows:

a. GARS staff shall confirm with the party receiving the verbal expedited Appeal that he or she verified with the Appealing Party the facts and basis of the request for expedited

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Appeal. The validated verbal acknowledgement shall be documented in the CalOptima database.

b. GARS staff shall send an acknowledgement letter for verbal Appeal requests to the Member to confirm the facts and basis of the expedited Appeal to ensure the request is properly and accurately noted and addressed by CalOptima. Notice should advise the Member to contact CalOptima if the acknowledgement letter does not correctly capture the Member's request.

4.6. GARS staff shall verify that the request meets all criteria for processing as an expedited Appeal.:

a. StaffGARS staff shall verify that the requestor is the Member, or the Member's Authorized Representative. If the requestor is not the Member, or the Member's Authorized Representative, staff shall request treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician. If the requestor is not one of these parties, GARS staff shall request, in writing, that the requestor to submit documentation of the requestor's status as the Member's Authorized Representative. AnIncluded with the request, staff shall send an Appointment of Representative Form may be faxed to the requestor, and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for an expedited Appeal determination.

i. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, staff shall make and document asat least two (2) telephone calls to the requestor in an attempt to obtain documentation.

ii. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative within seventy-two (72) hours or no later than the end of the fourteen (14) calendar day extension if CalOptima extended the timeframe, after CalOptima's receipt of the expedited Appeal:

a) CalOptima shall dismiss the Appeal and notify the Member, in writing, that the request for Appeal shall be dismissed due to lack of the required documentation to process the request using the Notice of Dismissal of Appeal Request.

1) The dismissal would be no sooner than seventy-two (72) hours and no later than an additional fourteen (14) calendar days when an extension is granted.

2) The dismissal notice shall inform the Member of the process and his or her right to request a review of the dismissal by an Independent Review Entity (IRE).IRE and that such request must be filed within sixty (60) calendar days from the date of receipt of CalOptima's written dismissal notice.

b. StaffGARS staff shall determine if the Member received the notice of an adverse Organization Determination, and request a copy of such notice by facsimile, or email, from the Member's Health Network. If the Member did not receive notice of an adverse Organization Determination, staff shall submit the request to CalOptima's Utilization Management Department, or the Health Network, to make an Organization Determination.

c. AGARS staff shall review the notice of adverse Organization Determination to verify that CalOptima received the request for expedited Appeal within sixty-five (65) days after the date of notice. If CalOptima received the request later than sixty-five (65) days after the date of notice, GARS staff shall provide the over sixty (60) day letter to the Appealing

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Party, indicating that the request does not meet criteria for expedited Appeal unless the Appealing Party provides good cause for an extension, in accordance with Sections III.B.1.b.i.-ii. of this Policy.

d. If CalOptima determines a Member's ~~physician, or CalOptima's~~ expedited Appeal was misclassified as an expedited Grievance and later discovers the error, CalOptima shall notify the Member, in writing, of the misclassified expedited Appeal, and immediately process the reclassified expedited Appeal through the expedited Appeal process in accordance with this Policy. CalOptima shall consider the date of receipt of the original request as the date of receipt of the expedited Appeal and not as the date the misclassification was discovered.

e. Medical criteria determination for an expedited Appeal:

i. CalOptima's Medical Director~~,~~ shall determine if the request meets medical criteria for an expedited Appeal, ~~in accordance with Section II.A. of this policy.~~when the Appeal request is made by the Member or a Member's Authorized Representative.

ii. If a Member's treating physician acting on behalf of the Member makes or supports a request for an expedited Appeal, the request is presumed to meet medical criteria for an expedited Appeal, and CalOptima Medical Director review is not required.

7. If the Member's physician~~,~~ or CalOptima's Medical Director~~,~~ determines that the request does not meet criteria for an expedited Appeal, staff shall refer the request to the ~~Standard~~standard Appeal process, in accordance with CalOptima Policy MA.9003: Standard Pre-Service Appeal.

a. Staff shall notify the Member verbally ~~within~~no later than seventy-two (72) hours after receipt of the request for Appeal, and in writing ~~within~~no later than three (3) calendar days after the verbal notification with a letter that includes:

i. Notice that CalOptima shall automatically transfer and process the request as a ~~Standard~~standard Appeal;

ii. Notice that CalOptima shall expedite any request for Appeal in which a physician indicates that applying the standard timeframe for making a determination may seriously jeopardize the Member's life, health, or ability to regain maximum function; and

iii. The Member's right to file an ~~Expedited~~expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process, and Grievance instructions and timeframes.

b. If the expedited Appeal request is instead determined as a standard Appeal request, the timeframe for the Appeal determination shall begin the day CalOptima receives the request for expedited Appeal.

~~b.~~c. If the Member disagrees with CalOptima's decision to process the request as a ~~Standard~~standard Appeal, the Member may request an Expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process.

8. Staff shall complete the case file with appropriate information and documents that include, but ~~is~~are not limited to:

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a. Documentation of the Member's Medicare eligibility status;

b. The Member's request for expedited Appeal;

c. A copy of corresponding facility, home health, or physician's records;

d. A copy of utilization records related to the Member's admission and discharge;

e. A copy of a Detailed Explanation of Non-coverage (DENC), Notice of Medicare Non-Coverage (NOMNC), or other notice of non-coverage provided to the Member, or Authorized Representative~~.~~;

f. A copy of all records considered for the initial Organization Determination;

g. A copy of the notice of the Organization Determination; and

h. Any additional records mentioned by the Member, or physician.

9. If CalOptima needs additional information from a Provider to make a determination, it shall request such information within twenty-four (24) hours of receipt of the request for an expedited Appeal.

~~D.~~E. Expedited Pre-Service Appeal Determination

1. CalOptima shall designate an individual, other than the person involved in making the initial Organization Determination, to review a request for expedited Appeal.

a. If CalOptima based the original denial on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested item, service, or drug in question, shall review the request for expedited Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the item, service, or drug in question, but need not be of the same specialty, or subspecialty, as the treating physician.

b. If the request for expedited Appeal involves emergency services, CalOptima shall apply the prudent layperson standard when making the expedited Appeal determination.

2. GARS staff shall present the expedited Appeal to the designated reviewer for decision.

3. GARS staff shall document the decision and the rationale for the decision in CalOptima's database.

~~2.~~4. If, upon expedited Appeal, CalOptima completely reverses the adverse Organization Determination, staff shall:

a. Notify the ~~Member, the Authorized Representative, or the physician~~Appealing Party who requested the expedited Appeal and all involved parties of the decision, verbally, no later than seventy-two (72) hours after CalOptima's receipt of the request for expedited Appeal;

b. Notify the ~~Member~~Appealing Party of the decision, in writing, ~~within~~no later than three (3) calendar days ~~after~~of the verbal ~~notice;~~notification.

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c. Coordinate with CalOptima's Utilization Management Department, or the Member's Health Network, to arrange for the ordered service or continuation of services as soon as medically indicated, but not later than seventy-two (72) hours or no later than the fourteen (14) calendar day extension if CalOptima extended the timeframe, after CalOptima receives the request for expedited Appeal;

d. Notify the Member's requesting Provider of CalOptima's decision;

~~d.~~e. Ensure that the Member's case file includes documentation of ~~payment, or~~the authorization or provision; and

~~e.~~f. Note the expedited Appeal as "closed" in the Appeal database.

~~3.~~5. If, upon Appeal, CalOptima affirms, in whole or in part, the adverse Organization Determination, ~~it~~CalOptima shall take the following actions:

a. GARS staff shall notify the ~~Member, the Member's Authorized Representative, or physician~~Appealing Party who requested the expedited Appeal of CalOptima's decision, verbally, ~~within~~ no later than seventy-two (72) hours after receipt of the request for expedited Appeal, or no later than the fourteen (14) calendar day extension if CalOptima extended the timeframe, and notify the ~~member~~Appealing Party, in writing, ~~within~~ no later than three (3) calendar days after the verbal notification. ~~The notice shall~~GARS will notify the Member upon forwarding the case to the IRE of the following by using the model Notice of Appeal Status:

i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

ii. Direct the Member to submit such evidence to the IRE; and

iii. Include information regarding how the Member may contact the IRE.

~~i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;~~

~~ii.~~i. ~~Direct the Member to submit such evidence to the IRE; and~~

~~iii.~~i. ~~Include information regarding how the Member may contact the IRE.~~

b. ~~Staff~~GARS staff shall mail ~~the~~ or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file, following receipt of CalOptima's expedited Appeal determination, within twenty-four (24) hours of the expedited Appeal decision (both expedited Appeals and Part B Drug Appeals). The following should be included in the case file forwarded to the IRE:

i. Appeal Case File Cover Sheet;

ii. Reconsideration Background ~~Data~~Date Form~~,~~ (not required if submitting via IRE web portal);

iii. Case Narrative ~~Form, and case file~~;

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iv. Copy of the initial Adverse Organization Determination Request and Notice;

v. Copy of the Appeal Request and Notice;

vi. Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Member, provider, and/or prescriber);

vii. Representation documentation for representative Appeals;

viii. A complete copy of the relevant EOC on a compact disc (CD) (if file is not submitted via IRE web portal); and

ix. Dismissal Case File Data Form.

~~b.~~c. If GARS staff is unable to upload the case files (expedited Appeal or Part B Drug Appeal) through the IRE QIC Appeals Portal, GARS staff shall submit the case files to the IRE by overnight mail/next day delivery, within twenty-four (24) hours after the decision~~, and no later than twenty-four (24) hours after the timeframes specified in Sections III.B.1. and III.B.2. of this policy, whichever is first.~~ is rendered.

~~4.~~6. Upon ~~a Member's~~an Appealing Party's request, CalOptima shall provide the ~~Member~~Appealing Party with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and other pertinent information used to support CalOptima's decision. CalOptima shall provide records at no cost.

~~E.~~F. IRE Determination

1. The IRE will make a decision on an expedited Appeal within seventy-two (72) hours after receipt of the request from CalOptima.

2. The IRE may request additional information from CalOptima within a specified timeframe, using the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Cover Sheet and Request for Information Response Letter to IRE.

~~2.~~3. If the IRE upholds CalOptima's initial adverse Organization Determination, the IRE shall notify CalOptima and the Member of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Member's Appeal file~~,~~ and update the Appeal tracking system.

~~3.~~4. If the IRE overturns~~,~~ or partially overturns~~,~~ CalOptima's initial adverse Organization Determination, GARS staff shall:

a. Send a ~~notification~~notice of compliance letter to the Member~~, and a copy~~;

~~a.~~b. Notify the Member's Provider of ~~such letter to~~ the ~~IRE~~IRE's decision;

~~b.~~c. Coordinate with CalOptima' Utilization Management Department~~,~~ or the Member's Health Network~~,~~ to arrange for the ordered service or continuation of services, as soon as medically indicated, but not later than seventy-two (72) hours after the notice from the IRE; ~~and~~

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d. Send a notice of compliance to the IRE using the Statement of Compliance Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

~~e.~~e. Document all activities in the Appeal tracking system.

~~F.~~G. Administrative Law Judge (ALJ) Hearing

1. ~~A Member, or the Member's Authorized Representative,~~An Appealing Party has the right to a hearing before an ALJ if the projected value of the disputed service meets the threshold amount set by CMS.

2. ~~A Member or the Member's Authorized Representative~~An Appealing Party shall request an ALJ hearing by submitting such request:

   a. In writing to CalOptima, or the IRE; and

   b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. ~~The Member, or the Member's Authorized Representative,~~The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Member, or Authorized Representative, cannot meet the timeframe, in accordance with Title 20, Code of Federal Regulations, Section 404.911.

3. If CalOptima receives a request for an ALJ hearing from ~~a Member, or a Member's Authorized Representative~~an Appealing Party, GARS staff shall forward the request to the IRE. The IRE will compile and forward the Member's file to the ALJ.

4. Although CalOptima does not have a right to request an ALJ hearing, it may be a party to the hearing.

5. If the ALJ reverses CalOptima's initial adverse Organization Determination, in whole or in part, CalOptima shall:

   a. Authorize~~,~~ or provide~~,~~ the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless CalOptima requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.G. of this ~~policy~~Policy. If CalOptima requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

   b. Inform the IRE when it effectuates the decision.

~~G.~~H. ~~Medicare Appeals Council (~~MAC~~)~~ Review

1. Any party, including CalOptima, that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC review of the ALJ decision~~,~~ or dismissal~~,~~ by filing a written request to the MAC.

2. A party requesting a MAC review shall submit such request:

   a. In writing directly to the MAC; and

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b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party can demonstrate good cause.

3. If CalOptima receives ~~a Member's, or~~ an ~~Authorized Representative's,~~Appealing Party's request for a MAC review, it shall forward a copy of the Member's letter requesting such MAC review, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima requests a MAC Review, it shall:

   a. Submit a letter and a complete case file to the MAC;

   b. Concurrently notify the Member of CalOptima's request by sending the Member a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its own motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties in writing of its decision to initiate such review.

6. If the MAC reverses CalOptima's initial adverse Organization Determination in whole, or in part, CalOptima shall:

   a. Authorize~~,~~ or provide~~,~~ the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

~~H.~~I. Judicial Review

1. Any party, including CalOptima, may request judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

   b. The amount in controversy meets the CMS designated amount for judicial reviews.

2. Any party, including CalOptima, may request judicial review of a MAC decision if:

   a. The MAC denied the party's request for review; or

   b. It is the final decision of CMS; and

   c. The amount in controversy meets the CMS designated amount for judicial reviews.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima shall notify all other parties to an expedited Appeal prior to requesting a judicial review.

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6. If the judicial review reverses CalOptima's initial adverse Organization Determination in whole, or in part, CalOptima shall:

   a. Authorize~~,~~ or provide~~,~~ the service under dispute as directed by the Court, or as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination~~,~~; if the Court does not specify a time for performance; and

   b. Inform the IRE when it effectuates the decision.

~~I.~~J. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources, including, but not limited to, Grievances, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Board of Directors, with recommendations for interventions, as appropriate.

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~~III.~~IV. ATTACHMENT(S)

~~A. Appointment of Representative Form~~
~~B. Appeal Acknowledgement, Does Not Meet Expedited~~
~~C. Notice of Right To An Expedited Grievance~~
~~D. Reconsideration Background Data Form~~
~~E. Case Narrative Form~~
~~F. Notice to Independent Review Entity Upholding Decision, Expedited Appeal~~
~~G. Notice to Member of Favorable Outcome~~
~~H. Notice to Member of Unfavorable Outcome~~
~~I. Notice of Appeal Status~~
Not Applicable

~~IV.~~V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy HH.1104: Complaints of Discrimination
C. CalOptima Policy MA.4002: Cultural and Linguistic Services
~~C.~~D. CalOptima Policy MA.9002: Member Grievance Process
~~D.~~E. CalOptima Policy MA.9003: Standard Pre-Service Appeal
~~E.~~F. ~~"~~Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures~~," Health Plan Management System (HPMS) Memorandum, Issued 09/10/2013~~
G. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
H. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
~~F.~~I. Medicare Managed Care Manual, Chapter 13
~~G.~~J. OneCare Evidence of Coverage/Member Handbook
K. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
~~H.~~L. Social Security Act, §205(g)
~~I.~~M. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq.

~~V.~~VI. REGULATORY AGENCY APPROVAL(S)

None to Date

~~VI.~~VII. BOARD ACTION(S)

Date	Meeting

~~VII.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.9004	Expedited Service Appeal	OneCare
Revised	10/01/2012	MA.9004	Expedited Service Appeal	OneCare
Revised	01/01/2014	MA.9004	Expedited Service Appeal	OneCare
Revised	12/01/2016	MA.9004	Expedited Appeal	OneCare
Revised	01/01/2018	MA.9004	Expedited Appeal	OneCare
Revised	04/01/2022	MA.9004	Expedited Pre-Service Appeal	OneCare

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~~VIII.~~IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse ~~organization~~initial determination made by CalOptima on ~~the~~ health care services ~~a member~~or benefits under Part C the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services ~~(such that~~ or drug coverage (when a delay would adversely affect the health of the ~~member~~Member), or on any amounts the ~~member~~Member must pay for a service~~.~~ or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration ~~by CalOptima and if necessary,~~ a reconsideration by an independent review entity~~, hearings before~~ (IRE), adjudication by an Administrative ~~Law Judges (ALJs),~~(ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.
Appealing Party	For purposes of this Policy, this is a Member, a Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician.
Authorized Representative	~~Any individual appointed by a Member, or authorized under state or other applicable law, to act on behalf of a member in an organization or coverage determination, grievance, or appeal.~~An individual who is the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member 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, and does not provide broad legal authority to make another individual's healthcare decisions.
Expedited Grievance	A Grievance involving: 1. CalOptima's decision to invoke an extension relating to an Organization Determination or a Reconsideration; or 2. CalOptima's refusal to grant a Member's request for an Expedited Organization Determination or Reconsideration.
Expedited Service Appeal	A Service Appeal in which the thirty (30) calendar day process could seriously jeopardize the Member's life, health, or ability to regain maximum function.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review denial of Coverage Determinations.
Medical ~~Records~~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.
~~Members~~Member	~~An enrollee -~~A beneficiary ~~of a~~enrolled in the CalOptima OneCare program.

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Term	Definition
Organization Determination	Any determination made by CalOptima, or its delegated entity with respect ~~to any of~~ the following: 1. Payment for temporarily ~~Out~~out-of-~~Area~~area renal dialysis services, ~~Emergency Services~~emergency services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima. 3. ~~CalOptima's refusal~~Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, ~~that~~which the Member believes should be furnished or arranged ~~for~~ by CalOptima; 4. Reduction or premature discontinuation, of a previously authorized ~~service~~ongoing course of treatment; or 5. ~~CalOptima's failure~~Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide ~~the Member with~~ timely notice of an adverse determination, such that a delay would adversely affect the ~~Member's~~ health of the Member.
Pre-Service	Review of any case or service that requires approval by OneCare or a Health Network, in whole or in part, in advance of the Member obtaining medical care or services. Pre-authorization and precertification are pre-service decisions.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, ~~Physician Medical Group~~Health Network, or other person or institution who furnishes Covered Services.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.

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Policy:	MA.9004
Title:	**Expedited Pre-Service Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy addresses Medicare Part C Appeals and describes the process by which CalOptima ensures that Members have clear and reliable access to an expedited Appeal process for Pre-Service Organization Determination, consistent with Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. If an Appealing Party believes that CalOptima's thirty (30) calendar day standard Appeal process could seriously jeopardize the Member's life, health, or ability to regain maximum function, the Appealing Party may request an expedited Appeal, in accordance with the terms and conditions of this Policy.

B. CalOptima shall process an expedited Appeal within seventy-two (72) hours after receiving the request for an expedited Appeal.

C. The processing timeframe for an expedited Appeal shall begin when the appropriate department within CalOptima receives the request.

D. If CalOptima denies a request for an expedited Appeal, it shall process the request as a standard Appeal, in accordance with CalOptima Policy MA.9003: Standard Pre-Service Appeal.

E. If a physician makes, or supports, a request for an expedited Appeal, CalOptima shall grant such request, and shall process the request as an expedited Appeal.

F. A Member shall have the right to be represented by an attorney or other representative in the expedited Appeal process.

G. Grievance and Appeal Resolution Services (GARS) Department staff shall be responsible for tracking and reporting all expedited Appeals.

H. CalOptima's Utilization Management Department shall be responsible for designating, training, and monitoring a clinical on-call nurse to accept and initiate the expedited Appeal process.

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Back To Item Back to Agenda

I. CalOptima or the Member's Health Network shall notify the Member of the expedited Appeal process:

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage and periodic Member newsletters;

3. In all notices of adverse Organization Determination and non-coverage;

4. Upon involuntary disenrollment; and

5. Upon a Member's request.

J. Upon request, CalOptima shall provide a Member with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and information used to support CalOptima's decision.

K. CalOptima shall provide all parties to an expedited Appeal with reasonable opportunity to present evidence, or allegations of fact or law, related to the issue in dispute, in person, or in writing. CalOptima shall take all evidence into account when making its decision.

L. If an expedited Appeal involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

M. CalOptima shall ensure that there is no discrimination against a Member on the grounds that such Member filed an Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

N. CalOptima shall ensure that Members have equal access to, and can fully participate in, the expedited Appeal process by providing assistance to Members with limited English proficiency, vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

O. If GARS staff identifies a potential quality of care issue, he or she shall refer the issue to the Quality Improvement (QI) Department, in accordance with CalOptima Policy MA.9002: Member Grievance Process.

III. PROCEDURE

A. Parties to an Expedited Pre-Service Appeal

1. An Appealing Party may file an expedited Appeal.

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a. A Member or an individual appointed by the Member (e.g., relative, friend, advocate, attorney) as his or her Authorized Representative may file an expedited Appeal. If an Authorized Representative files an expedited Appeal, he or she shall submit documentation of such appointment, as follows:

i. Appropriate legal documents, or authority, supporting such appointment; or

ii. Appointment of Representative Form, or equivalent written notice (Representative Forms) signed by both the Member and the Authorized Representative, except if an attorney acts as the Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit an Appointment of Representative Form, or equivalent written notice, signed by the Member only.

b. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Member in filing an expedited Appeal.

i. Authorized Representatives could include, but are not limited to, a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

ii. The Authorized Representative must produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

2. A Provider shall not charge a Member to act as the Member's Authorized Representative.

B. Request for an Expedited Pre-Service Appeal

1. If an Appealing Party believes that CalOptima's thirty (30) calendar day standard Appeal process may seriously jeopardize the Member's life, health, or ability to regain maximum function, the Appealing Party may request an expedited Appeal verbally, by telephone, or in person with the Customer Service Department, or in writing to CalOptima within sixty (60) calendar days from the date of the notice of the initial adverse Organization Determination.

a. CalOptima may accept a request for an expedited Appeal filed after the sixty (60) calendar day limit, if the Appealing Party submits a written request for an extension of the timeframe for good cause.

i. In its request for an extension, the Appealing Party must include a statement explaining why the request for an expedited Appeal was not filed on time.

ii. If the request for an extension submitted does not include an explanation as to why the request for an expedited Appeal was not filed on time, CalOptima may attempt to obtain information supporting good cause for the late filing.

iii. In making its determination, CalOptima should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

iv. CalOptima shall ensure that there is no discrimination against a Member in the determination of good cause justification when an expedited Appeal request is outside

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the sixty (60) calendar day limit, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

v. Instances where good cause may exist include, but are not limited to:

a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

b) The Appealing Party being seriously ill, which prevented a timely expedited Appeal;

c) Death or serious illness in the Appealing Party's immediate family;

d) An accident causing important records to be destroyed;

e) Difficulty in locating and/or receiving necessary documents within the established time limits;

f) Incomplete or incorrect information regarding the expedited Appeal process;

g) The Appealing Party's lack of capacity to understand the expedited Appeal filing timeframe;

h) The Appealing Party sending the request to an incorrect address, in good faith, within the established time limit;

i) The delay resulted from additional time required to produce Member documents in an accessible format pursuant to CalOptima Policy MA.4002: Cultural and Linguistic Services; or

j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program or senior center), on account of his or her disability, in order to be able to file the expedited Appeal.

vi. If CalOptima denies the Appealing Party's request for good cause extension, CalOptima must dismiss such request and the Appealing Party may file a Grievance in accordance with CalOptima Policy MA.9002: Member Grievance Process.

2. An expedited Appeal request shall be considered received on the date and time:

a. When the appropriate department within CalOptima initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima and the appropriate department within CalOptima receives such document;

c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

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e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the expedited Appeal request or supporting statements after normal business hours); or

f. An expedited Appeal request is received through CalOptima's website.

3. An Appealing Party who requests an expedited Appeal, may withdraw such request at any time before CalOptima renders a decision by notifying CalOptima of such withdrawal verbally or in writing.

a. If that party withdraws the expedited Appeal request verbally, CalOptima shall mail that party a written confirmation of the withdrawal to the party within three (3) calendar days from the date of the verbal request.

b. If the withdrawal request is received after CalOptima has forwarded the case file to the Independent Review Entity (IRE), then CalOptima must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima or a delegated entity not responsible for processing Appeals that incorrectly receives an expedited Appeal request, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

C. Expedited Pre-Service Appeal Timeframe

1. Subject to the provisions of this Policy, CalOptima shall make an expedited Appeal determination, as expeditiously as the Member's case requires, based on the Member's health status, but not later than seventy-two (72) hours after receipt of a request for such expedited Appeal for items and services, unless a fourteen (14) calendar day extension has been granted. Part B drug timeframes cannot be extended.

a. The expedited Appeal processing timeframe begins when the appropriate CalOptima department receives an expedited Appeal request.

b. If CalOptima obtains information establishing good cause for late filing, the adjudication timeframe of the expedited Appeal request begins on the date CalOptima receives that information.

c. CalOptima shall inform the Member or Member's Authorized Representative of the right to request a fourteen (14) calendar day extension if additional time is needed to submit evidence related to an expedited Appeal.

2. CalOptima may extend the timeframe for an expedited Appeal determination for items and services by up to fourteen (14) additional calendar days upon the Member's request (except for Part B drugs), or if CalOptima needs additional information to make a determination, and such extension is justified and in the Member's best interest due to the need for additional medical evidence from a non-contracted Provider that may change CalOptima's decision to deny an item or service, or it is the Member's best interest due to extraordinary, exigent, or other non-routine circumstances. If CalOptima extends the timeframe for an expedited Appeal determination, it shall provide the Member with written notice that includes:

a. The reason for the extension;

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b. The Member's right to file an Expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process, if he or she disagrees with CalOptima's decision to extend the timeframe; and

c. Information that the Member may resubmit the request for an expedited Appeal, and that CalOptima shall expedite a request for expedited Appeal that is supported by a physician.

3. Subject to the provisions of this Policy, CalOptima shall make an expedited Appeal determination for Part B drugs, as expeditiously as the Member's case requires, based on the Member's health status, but not later than seventy-two (72) hours after receipt of a request for such Appeal type. Part B drugs timeframes cannot be extended.

4. If CalOptima fails to provide an Appealing Party who requests an expedited Appeal with an Appeal determination within the timeframes specified in Sections III.C.1.-3. of this Policy:

a. CalOptima shall consider such failure as an affirmation of the adverse Organization Determination;

b. CalOptima shall forward the complete case file of the expedited Appeal request to the IRE no later than twenty-four (24) hours after the expedited Appeal decision, or no later than the fourteen (14) calendar day extension from receipt of the expedited Appeal request if CalOptima extended the timeframe, in accordance with Section III.E.5.b-c. of this Policy; and

c. CalOptima GARS shall notify the Appealing Party who requested the expedited Appeal, in writing, that CalOptima forwarded the request to the IRE for final determination by using the model Notice of Appeal Status, which will:

i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

ii. Direct the Member to submit such evidence to the IRE; and

iii. Include information regarding how the Member may contact the IRE.

D. Expedited Pre-Service Appeal Processing

1. CalOptima shall route a request for an expedited Service Appeal as follows:

Contact Type	Monday–Friday **08:00–17:30**	Evenings **17:31–07:59**	Weekends **Friday 17:31–Monday 07:59**	Holidays **24 hrs/day**
Telephone	Route to GARS	On-call answering service directs call to the on-call nurse	On-call answering service directs call to the on-call nurse	On-call answering service directs call to the on-call nurse
Facsimile	Take to GARS immediately	N/A	N/A	N/A

2. A GARS staff member shall administer each request for expedited Appeal.

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3. For expedited Appeals received by CalOptima after hours during the evening, or on weekends, or holidays an on-call nurse shall initiate the process for such Appeal request by:

    a. Forwarding notice of CalOptima's or the Health Network's adverse Organization Determination and the Member's Medical Records to CalOptima's on-call Medical Director for clinical review, to determine whether such request meets medical criteria for an expedited Appeal.

    b. Notifying the Appealing Party verbally, whether request meets medical criteria for an expedited Appeal.

        i. If request does not meet criteria, the Appeal shall be processed in accordance with Sections III.D.7.a-c. of this Policy.

        ii. If the request meets criteria, CalOptima's on-call Medical Director shall make a determination, as expeditiously as the Member's case requires, but no later than seventy-two (72) hours after receipt of a request for such expedited Appeal.

4. Upon receipt of a request for Appeal, GARS staff shall:

    a. Date stamp and code the request with the appropriate categorization in the database; and

    b. Prepare a case file that contains the original request for expedited Appeal, notice of CalOptima's or the Health Network's adverse Organization Determination, and all other correspondence.

5. If a Member makes a verbal expedited Appeal, GARS staff shall request confirmation of such Appeal as follows:

    a. GARS staff shall confirm with the party receiving the verbal expedited Appeal that he or she verified with the Appealing Party the facts and basis of the request for expedited Appeal. The validated verbal acknowledgement shall be documented in the CalOptima database.

    b. GARS staff shall send an acknowledgement letter for verbal Appeal requests to the Member to confirm the facts and basis of the expedited Appeal to ensure the request is properly and accurately noted and addressed by CalOptima. Notice should advise the Member to contact CalOptima if the acknowledgement letter does not correctly capture the Member's request.

6. GARS staff shall verify that the request meets all criteria for processing as an expedited Appeal:

    a. GARS staff shall verify that the requestor is the Member, the Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician. If the requestor is not one of these parties, GARS staff shall request, in writing, that the requestor submit documentation of the requestor's status as the Member's Authorized Representative. Included with the request, staff shall send an Appointment of Representative Form, and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for an expedited Appeal determination.

        i. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, staff shall make and document at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

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ii. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative within seventy-two (72) hours or no later than the end of the fourteen (14) calendar day extension if CalOptima extended the timeframe, after CalOptima's receipt of the expedited Appeal:

a) CalOptima shall dismiss the Appeal and notify the Member, in writing, that the request for Appeal shall be dismissed due to lack of the required documentation to process the request using the Notice of Dismissal of Appeal Request.

1) The dismissal would be no sooner than seventy-two (72) hours and no later than an additional fourteen (14) calendar days when an extension is granted.

2) The dismissal notice shall inform the Member of the process and his or her right to request a review of the dismissal by an IRE and that such request must be filed within sixty (60) calendar days from the date of receipt of CalOptima's written dismissal notice.

b. GARS staff shall determine if the Member received the notice of an adverse Organization Determination, and request a copy of such notice by facsimile, or email, from the Member's Health Network. If the Member did not receive notice of an adverse Organization Determination, staff shall submit the request to CalOptima's Utilization Management Department or the Health Network to make an Organization Determination.

c. GARS staff shall review the notice of adverse Organization Determination to verify that CalOptima received the request for expedited Appeal within sixty-five (65) days after the date of notice. If CalOptima received the request later than sixty-five (65) days after the date of notice, GARS staff shall provide the over sixty (60) day letter to the Appealing Party, indicating that the request does not meet criteria for expedited Appeal unless the Appealing Party provides good cause for an extension, in accordance with Sections III.B.1.b.i.-ii. of this Policy.

d. If CalOptima determines a Member's expedited Appeal was misclassified as an expedited Grievance and later discovers the error, CalOptima shall notify the Member, in writing, of the misclassified expedited Appeal, and immediately process the reclassified expedited Appeal through the expedited Appeal process in accordance with this Policy. CalOptima shall consider the date of receipt of the original request as the date of receipt of the expedited Appeal and not as the date the misclassification was discovered.

e. Medical criteria determination for an expedited Appeal:

i. CalOptima's Medical Director shall determine if the request meets medical criteria for an expedited Appeal, when the Appeal request is made by the Member or a Member's Authorized Representative.

ii. If a Member's treating physician acting on behalf of the Member makes or supports a request for an expedited Appeal, the request is presumed to meet medical criteria for an expedited Appeal, and CalOptima Medical Director review is not required.

7. If the Member's physician or CalOptima's Medical Director determines that the request does not meet criteria for an expedited Appeal, staff shall refer the request to the standard Appeal process, in accordance with CalOptima Policy MA.9003: Standard Pre-Service Appeal.

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a. Staff shall notify the Member verbally no later than seventy-two (72) hours after receipt of the request for Appeal, and in writing no later than three (3) calendar days after the verbal notification with a letter that includes:

i. Notice that CalOptima shall automatically transfer and process the request as a standard Appeal;

ii. Notice that CalOptima shall expedite any request for Appeal in which a physician indicates that applying the standard timeframe for making a determination may seriously jeopardize the Member's life, health, or ability to regain maximum function; and

iii. The Member's right to file an expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process, and Grievance instructions and timeframes.

b. If the expedited Appeal request is instead determined as a standard Appeal request, the timeframe for the Appeal determination shall begin the day CalOptima receives the request for expedited Appeal.

c. If the Member disagrees with CalOptima's decision to process the request as a standard Appeal, the Member may request an Expedited Grievance, in accordance with CalOptima Policy MA.9002: Member Grievance Process.

8. Staff shall complete the case file with appropriate information and documents that include, but are not limited to:

a. Documentation of the Member's Medicare eligibility status;

b. The Member's request for expedited Appeal;

c. A copy of corresponding facility, home health, or physician's records;

d. A copy of utilization records related to the Member's admission and discharge;

e. A copy of a Detailed Explanation of Non-coverage (DENC), Notice of Medicare Non-Coverage (NOMNC), or other notice of non-coverage provided to the Member, or Authorized Representative;

f. A copy of all records considered for the initial Organization Determination;

g. A copy of the notice of the Organization Determination; and

h. Any additional records mentioned by the Member, or physician.

9. If CalOptima needs additional information from a Provider to make a determination, it shall request such information within twenty-four (24) hours of receipt of the request for an expedited Appeal.

E. Expedited Pre-Service Appeal Determination

1. CalOptima shall designate an individual, other than the person involved in making the initial Organization Determination, to review a request for expedited Appeal.

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a. If CalOptima based the original denial on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested item, service, or drug in question, shall review the request for expedited Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the item, service, or drug in question, but need not be of the same specialty, or subspecialty, as the treating physician.

b. If the request for expedited Appeal involves emergency services, CalOptima shall apply the prudent layperson standard when making the expedited Appeal determination.

2. GARS staff shall present the expedited Appeal to the designated reviewer for decision.

3. GARS staff shall document the decision and the rationale for the decision in CalOptima's database.

4. If, upon expedited Appeal, CalOptima completely reverses the adverse Organization Determination, staff shall:

a. Notify the Appealing Party who requested the expedited Appeal and all involved parties of the decision, verbally, no later than seventy-two (72) hours after CalOptima's receipt of the request for expedited Appeal;

b. Notify the Appealing Party of the decision, in writing, no later than three (3) calendar days of the verbal notification.

c. Coordinate with CalOptima's Utilization Management Department, or the Member's Health Network, to arrange for the ordered service or continuation of services as soon as medically indicated, but not later than seventy-two (72) hours or no later than the fourteen (14) calendar day extension if CalOptima extended the timeframe, after CalOptima receives the request for expedited Appeal;

d. Notify the Member's requesting Provider of CalOptima's decision;

e. Ensure that the Member's case file includes documentation of the authorization or provision; and

f. Note the expedited Appeal as "closed" in the Appeal database.

5. If, upon Appeal, CalOptima affirms, in whole or in part, the adverse Organization Determination, CalOptima shall take the following actions:

a. GARS staff shall notify the Appealing Party who requested the expedited Appeal of CalOptima's decision, verbally, no later than seventy-two (72) hours after receipt of the request for expedited Appeal, or no later than the fourteen (14) calendar day extension if CalOptima extended the timeframe, and notify the Appealing Party, in writing, no later than three (3) calendar days after the verbal notification. GARS will notify the Member upon forwarding the case to the IRE of the following by using the model Notice of Appeal Status:

i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

ii. Direct the Member to submit such evidence to the IRE; and

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iii. Include information regarding how the Member may contact the IRE.

b. GARS staff shall mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file, following receipt of CalOptima's expedited Appeal determination, within twenty-four (24) hours of the expedited Appeal decision (both expedited Appeals and Part B Drug Appeals). The following should be included in the case file forwarded to the IRE:

i. Appeal Case File Cover Sheet;

ii. Reconsideration Background Date Form (not required if submitting via IRE web portal);

iii. Case Narrative;

iv. Copy of the initial Adverse Organization Determination Request and Notice;

v. Copy of the Appeal Request and Notice;

vi. Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Member, provider, and/or prescriber);

vii. Representation documentation for representative Appeals;

viii. A complete copy of the relevant EOC on a compact disc (CD) (if file is not submitted via IRE web portal); and

ix. Dismissal Case File Data Form.

c. If GARS staff is unable to upload the case files (expedited Appeal or Part B Drug Appeal) through the IRE QIC Appeals Portal, GARS staff shall submit the case files to the IRE by overnight mail/next day delivery, within twenty-four (24) hours after the decision is rendered.

6. Upon an Appealing Party's request, CalOptima shall provide the Appealing Party with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and other pertinent information used to support CalOptima's decision. CalOptima shall provide records at no cost.

F. IRE Determination

1. The IRE will make a decision on an expedited Appeal within seventy-two (72) hours after receipt of the request from CalOptima.

2. The IRE may request additional information from CalOptima within a specified timeframe, using the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Cover Sheet and Request for Information Response Letter to IRE.

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3. If the IRE upholds CalOptima's initial adverse Organization Determination, the IRE shall notify CalOptima and the Member of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Member's Appeal file and update the Appeal tracking system.

4. If the IRE overturns or partially overturns CalOptima's initial adverse Organization Determination, GARS staff shall:

   a. Send a notice of compliance letter to the Member;

   b. Notify the Member's Provider of the IRE's decision;

   c. Coordinate with CalOptima' Utilization Management Department or the Member's Health Network to arrange for the ordered service or continuation of services, as soon as medically indicated, but not later than seventy-two (72) hours after the notice from the IRE;

   d. Send a notice of compliance to the IRE using the Statement of Compliance Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

   e. Document all activities in the Appeal tracking system.

G. Administrative Law Judge (ALJ) Hearing

1. An Appealing Party has the right to a hearing before an ALJ if the projected value of the disputed service meets the threshold amount set by CMS.

2. An Appealing Party shall request an ALJ hearing by submitting such request:

   a. In writing to CalOptima, or the IRE; and

   b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Member, or Authorized Representative, cannot meet the timeframe, in accordance with Title 20, Code of Federal Regulations, Section 404.911.

3. If CalOptima receives a request for an ALJ hearing from an Appealing Party, GARS staff shall forward the request to the IRE. The IRE will compile and forward the Member's file to the ALJ.

4. Although CalOptima does not have a right to request an ALJ hearing, it may be a party to the hearing.

5. If the ALJ reverses CalOptima's initial adverse Organization Determination, in whole or in part, CalOptima shall:

   a. Authorize or provide the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless CalOptima requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.G. of this Policy. If CalOptima requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

   b. Inform the IRE when it effectuates the decision.

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H. MAC Review

1. Any party, including CalOptima, that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC review of the ALJ decision or dismissal by filing a written request to the MAC.

2. A party requesting a MAC review shall submit such request:

   a. In writing directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party can demonstrate good cause.

3. If CalOptima receives an Appealing Party's request for a MAC review, it shall forward a copy of the Member's letter requesting such MAC review, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima requests a MAC Review, it shall:

   a. Submit a letter and a complete case file to the MAC;

   b. Concurrently notify the Member of CalOptima's request by sending the Member a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its own motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties in writing of its decision to initiate such review.

6. If the MAC reverses CalOptima's initial adverse Organization Determination in whole, or in part, CalOptima shall:

   a. Authorize or provide the service under dispute as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima, may request judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

   b. The amount in controversy meets the CMS designated amount for judicial reviews.

2. Any party, including CalOptima, may request judicial review of a MAC decision if:

   a. The MAC denied the party's request for review; or

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b. It is the final decision of CMS; and

c. The amount in controversy meets the CMS designated amount for judicial reviews.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima shall notify all other parties to an expedited Appeal prior to requesting a judicial review.

6. If the judicial review reverses CalOptima's initial adverse Organization Determination in whole, or in part, CalOptima shall:

a. Authorize or provide the service under dispute as directed by the Court, or as expeditiously as the Member's health condition requires, but no later than sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination if the Court does not specify a time for performance; and

b. Inform the IRE when it effectuates the decision.

J. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources, including, but not limited to, Grievances, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Board of Directors, with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy HH.1104: Complaints of Discrimination
C. CalOptima Policy MA.4002: Cultural and Linguistic Services
D. CalOptima Policy MA.9002: Member Grievance Process
E. CalOptima Policy MA.9003: Standard Pre-Service Appeal
F. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
G. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
H. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
I. Medicare Managed Care Manual, Chapter 13
J. OneCare Evidence of Coverage/Member Handbook
K. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
L. Social Security Act, §205(g)
M. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq.

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VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2005	MA.9004	Expedited Service Appeal	OneCare
Revised	10/01/2012	MA.9004	Expedited Service Appeal	OneCare
Revised	01/01/2014	MA.9004	Expedited Service Appeal	OneCare
Revised	12/01/2016	MA.9004	Expedited Appeal	OneCare
Revised	01/01/2018	MA.9004	Expedited Appeal	OneCare
Revised	04/01/2022	MA.9004	Expedited Pre-Service Appeal	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	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 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 a reconsideration by an independent review entity (IRE), adjudication by an Administrative (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.
Appealing Party	For purposes of this Policy, this is a Member, a Member's Authorized Representative, treating physician acting on behalf of the Member, or staff of physician's office acting on said physician's behalf or working under the direction of the physician.
Authorized Representative	An individual who is the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member 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, and does not provide broad legal authority to make another individual's healthcare decisions.
Expedited Grievance	A Grievance involving: 1. CalOptima's decision to invoke an extension relating to an Organization Determination or a Reconsideration; or 2. CalOptima's refusal to grant a Member's request for an Expedited Organization Determination or Reconsideration.
Expedited Service Appeal	A Service Appeal in which the thirty (30) calendar day process could seriously jeopardize the Member's life, health, or ability to regain maximum function.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review denial of Coverage Determinations.
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	A beneficiary enrolled in the CalOptima OneCare program.

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Term	Definition
Organization Determination	Any determination made by CalOptima, or its delegated entity with respect the following: 1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by CalOptima; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Pre-Service	Review of any case or service that requires approval by OneCare or a Health Network, in whole or in part, in advance of the Member obtaining medical care or services. Pre-authorization and precertification are pre-service decisions.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form and/or equivalent written notice.

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Policy:	MA.9005
Title:	**Payment Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/~~05~~2005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima shall ensure that Members have clear and reliable access to a Payment Appeal process that meets the ~~requirement~~requirements of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima shall establish and maintain a process that addresses the receipt, handling, and disposition of a Payment Appeal, in accordance with applicable statutes, regulations, contractual requirements, and the terms and conditions of this ~~policy~~Policy.

B. Grievance and Appeals Resolution Services (GARS) staff shall accept, track, and report all Payment Appeals.

C. Subject to the provisions of this ~~policy, a Member, a Member's Authorized Representative, or a Provider~~Policy, an Appealing Party may initiate a Payment Appeal.

1. When filing a Payment Appeal on behalf of a Member, a Provider may not charge a fee to the Member for doing so.

D. A Member shall have the right to an attorney, or other representation, in the Payment Appeal process.

E. If a Payment Appeal involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

~~E.~~F. Subject to the provisions of this ~~policy~~Policy, CalOptima shall process a Payment Appeal within sixty (60) calendar days after receipt of such Payment Appeal.

G. The processing timeframe for a Payment Appeal shall begin when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) received a Payment Appeal request.

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~~F.~~H. CalOptima shall notify a Member of the Payment Appeal process:

1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage and periodic Member newsletters;

3. In all notices of adverse Organization Determination; and

4. Upon the Member's request.

~~G.~~I. Upon request, CalOptima shall provide a Member with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and information used to support CalOptima's Payment Appeal decision.

~~H.~~J. All CalOptima departments shall respond promptly, within designated timeframes, to any inquiry related to a Payment Appeal.

~~I.~~K. CalOptima shall provide all parties to a Payment Appeal with reasonable opportunity to present evidence, or allegations~~,~~ of fact~~,~~ or law, related to the issue in dispute, in person, or in writing. CalOptima shall take all evidence into account when making its decision.

~~J.~~L. CalOptima shall ensure that there is no discrimination against a Member on the grounds that such Member filed a Payment Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

M. CalOptima shall ensure that Members have equal access to, and can fully participate in, the Payment Appeal process by providing assistance to Members with Limited English Proficiency (LEP), vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

III. PROCEDURE

A. Parties to a Payment Appeal

1. ~~A Member, or a Member's Authorized Representative,~~An Appealing Party may file a Payment Appeal.

   a. A Member may appoint any individual (e.g., relative, friend, advocate, attorney) as his or her Authorized Representative. If an Authorized Representative files ~~an~~a Payment Appeal, he or she shall submit documentation of such appointment, as follows:

      i. Appropriate legal documents~~,~~ or authority~~,~~ supporting such appointment; or

      ii. An Appointment of Representative Form~~,~~ or ~~similar~~equivalent written ~~statement,~~notice (Representative Form) signed by both the Member and the Member's Authorized

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Representative, except if an attorney acts as the Member's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for Appointment of Representative Form~~,~~ or ~~similar~~equivalent written ~~statement,~~notice signed by the Member only.

b. A ~~Provider shall not charge a fee to a Member~~ court acting in accordance with state or other applicable laws can authorize an individual to act ~~as~~on behalf of the ~~Member's~~Member in filing a Payment Appeal.

i. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

~~i.~~ii. The Authorized Representative~~.~~ shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

2. A Non-Contracted Provider, on his, her, or its own behalf, may file ~~a Payment~~an Appeal for a denied claim, in accordance with CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes, if such Non-Contracted Provider:

a. Furnished a Covered Service to a Member; and

b. Completes a ~~waiver~~Waiver of ~~liability~~Liability (WOL) statement that states that the Non-Contracted Provider shall not bill the Member for the Covered Service, regardless of the outcome of the Payment Appeal.

B. Request for Appeal

1. ~~A Member, a Member's Authorized Representative, or a Provider~~An Appealing Party may request ~~an~~a Payment Appeal ~~from CalOptima~~verbally, by ~~submitting a written request~~telephone, in-person with the Customer Service Department, or in writing to CalOptima within sixty (60) calendar days ~~after~~from the date of the receipt of notice of an adverse Organization Determination, or an Explanation of Benefits (EOB).

~~CalOptima shall allow a five (5) calendar day grace period for receipt of a mailed request for Appeal.~~

a. CalOptima may accept a request for Payment Appeal filed after the sixty (60) calendar day limit if the ~~Member, the Member's Authorized Representative, or Provider~~Appealing Party submits a written request for an extension of the timeframe for good cause.

i. ~~A Member, a Member's Authorized Representative, or a Provider who requests~~In its request for an extension, the Appealing Party must include a statement explaining why the request for Payment Appeal was not filed on time.

ii. If the request for an extension submitted does not include an explanation as to why the request for Payment Appeal was not filed on time, CalOptima may attempt to obtain information supporting good cause for the late filing.

iii. In making its determination, CalOptima should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

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iv. CalOptima shall ensure that there is no discrimination against a Member in the determination of good cause justification when a Payment Appeal request is outside the sixty (60) calendar day limit, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

v. Instances where good cause may exist include, but are not limited to:

a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

b) The Appealing Party was seriously ill which prevented a timely Payment Appeal;

c) Death or serious illness in the Appealing Party's immediate family;

d) An accident causing important records to be destroyed;

e) Difficulty in locating and/or receiving necessary documents within the established time limits;

f) Incomplete or incorrect information regarding the Payment Appeal process;

g) The Appealing Party's lack of capacity to understand the Payment Appeal filing timeframe;

h) The Appealing Party sent the request to an incorrect address, in good faith, within the established time limit;

i) The delay resulted from additional time required to produce Member documents in an accessible format pursuant to CalOptima Policy MA.4002: Cultural and Linguistic Services; or

j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program or senior center), on account of his or her disability, in order to be able to file the Payment Appeal.

iii. If CalOptima denies the Appealing Party's request for good cause extension, CalOptima must dismiss such request and the Appealing Party may file a Grievance in accordance with CalOptima Policy MA.9002: Member Grievance Process.

2. A Payment Appeal request shall be considered received on the date and time:

a. When any department within CalOptima initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima (or its designee);

c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

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e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

f. A Payment Appeal request is received through CalOptima's website.

3. An Appealing Party who requests a Payment Appeal may withdraw the request at any time before CalOptima renders a decision by notifying CalOptima of such withdrawal, verbally or in writing.

a. If that party withdraws the Payment Appeal request verbally, CalOptima shall mail that party a written confirmation of the withdrawal to the party within three (3) calendar days from the date of the verbal request.

b. If the withdrawal request is received after CalOptima has forwarded the case file to the Independent Review Entity (IRE), then CalOptima must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima or a delegated entity not responsible for processing Payment Appeals that incorrectly receives a Payment Appeal request, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

C. Payment Appeal Timeframe

1. Subject to the provisions of this Policy, CalOptima shall make ~~an Appeal~~a determination on a Payment Appeal ~~within~~ no later than sixty (60) calendar days after receipt of the request for Appeal.

a. The Payment Appeal processing timeframe begins when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives a Payment Appeal request.

b. If CalOptima obtains information establishing good cause for filing the Payment Appeal after the 60-day timely filing limit, the adjudication timeframe of the Payment Appeal request begins on the date CalOptima receives that information.

2. If CalOptima fails to provide ~~a Member, a Member's Authorized Representative, or Provider~~an Appealing Party who requests ~~an~~a Payment Appeal with a determination within the timeframes specified in Section III.C.1. of this ~~policy~~Policy:

a. CalOptima shall consider such failure as an affirmation of the adverse Organization Determination; and

b. CalOptima shall forward the request for Payment Appeal to the ~~Independent Review Entity (~~IRE~~) within~~ no later than sixty (60) calendar days after receiving the request for Payment Appeal~~.~~, in accordance with Sections III.E.5.b.-c.

c. CalOptima GARS will notify the Appealing Party who requested the Payment Appeal, in writing, that CalOptima forwarded the request to the IRE for final determination by using the model Notice of Appeal Status:

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i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

ii. Direct the Member to submit such evidence to the IRE; and

iii. Include information regarding how the Member may contact the IRE.

D. Appeal Processing

1. Upon receipt of a request for Appeal, GARS staff shall:

a. Date stamp, and code the request with ~~one (1) or more Reason Codes~~the appropriate categorization in the database; and

b. Prepare a case file that contains the original request for a Payment Appeal, notice of CalOptima's or a Health Network's adverse Organization Determination, and all other correspondence.

2. If a Member makes a verbal ~~Complaint, in accordance with CalOptima Policy MA.9001: Complaint Process, and GARS staff classifies such Complaint as a~~ Payment Appeal, GARS staff shall ~~mail a Verbal~~request confirmation of such as follows:

a. GARS staff shall confirm with the party receiving the verbal Payment Appeal that he or she verified with the Appealing Party the facts and basis of the request for Payment Appeal. The validated verbal acknowledgement shall be documented in the CalOptima database.

~~a.~~b. GARS staff shall send an Acknowledgement ~~letter~~Letter for verbal Payment Appeal requests to the Member to confirm the facts and basis of the ~~Appeal.~~Payment Appeal to ensure the request is properly and accurately noted and addressed by CalOptima. Notice should advise the Member to contact CalOptima if the Acknowledgement Letter does not correctly capture the Member's request.

~~2.~~3. GARS staff shall verify that the request meets criteria for processing as a Payment Appeal:

a. GARS staff shall verify that the requestor is a Member~~, or~~ a Member's Authorized Representative~~.~~, or a Provider. If the requestor is not ~~a Member, or a Member's Authorized Representative~~one of these parties, GARS staff shall request~~,~~ in writing, that the requestor ~~to~~ submit documentation of the requestor's status as the Member's Authorized Representative. Included with the request, staff shall send an Appointment of Representative Form and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for a Payment Appeal determination.

i. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, GARS staff shall ~~make~~:

a) Make and document at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

b) Inform the Member and purported representative, in writing, that CalOptima will not issue a decision for the Payment Appeal request until valid documentation is provided.

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ii. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative ~~within forty-four (44)~~ no later than sixty (60) calendar days after CalOptima's receipt of the Payment Appeal~~,~~:

a) CalOptima shall dismiss the Payment Appeal and notify the Member, in writing, that the request for Appeal shall be dismissed due to lack of the required documentation to process the request~~.~~ using the Notice of Dismissal of Appeal Request.

1) The dismissal would be no sooner than sixty (60) calendar days after receipt of the Payment Appeal.

~~1)~~2) The dismissal notice shall inform the Member of the process and his or her right to request a review of the dismissal by an Independent Review Entity (IRE~~).~~), in which, such request must be filed within sixty (60) calendar days from the date of receipt of CalOptima written dismissal notice.

b. GARS staff shall verify if CalOptima~~,~~ or a Health Network~~,~~ denied a claim for payment.

i. If CalOptima~~,~~ or a Health Network~~,~~ did not process the claim, GARS staff shall transmit the claim to the Claims Department~~,~~ or the Health Network~~,~~ for processing and shall notify the ~~Member, the Member's Authorized Representative, or Provider~~Appealing Party who requested the Appeal, of CalOptima's claims processing and Organization Determination process.

ii. If CalOptima~~,~~ or a Health Network~~,~~ did not deny the claim, GARS staff shall determine if the Member disputes a cost-sharing determination, or if the Provider who requests an Appeal disputes the payment amount.

c. GARS staff shall review the notice of adverse Organization Determination to verify that CalOptima received the request for Appeal within sixty-five (65) calendar days after the date of notice. If CalOptima received the request later than sixty-five (65) calendar days after the date of notice, GARS staff shall provide written notice, using the Over Sixty (60) Days Letter, to the ~~Member, the Member's Authorized Representative, or Provider~~Appealing Party who requested the Appeal. The notice shall inform the ~~Member, the Member's Authorized Representative, or Provider,~~Appealing Party that the request does not meet criteria for Appeal unless the requesting party provides good cause for an extension, in accordance with Section III.B.1.b.i-ii. of this ~~policy~~Policy.

~~3.~~4. If GARS staff identifies a potential quality of care issue, he or she shall forward a referral to the Quality Improvement ~~Department~~(QI) Department, in accordance with CalOptima Policy MA.9002: Member Grievance Process.

~~4. Upon verification that the request meets criteria for processing as a Payment Appeal, GARS staff shall send an Appeal Acknowledgment Letter to the Member, the Authorized Representative, or Provider who submitted the request for Appeal within five (5) business days after CalOptima receives such request.~~

5. GARS staff shall prepare the case file with appropriate information and documents that include, but are not limited to, the following:

a. A copy of the Member's eligibility status.

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b. If the Payment Appeal involves a denied hospital claim, including emergency room claims:

i. A copy of the Member's Medical Records;

ii. A copy of the notification of admission; and

iii. A copy of the notice of Organization Determination.

c. If the Payment Appeal involves a denied ambulance claim:

i. A copy of the transport record;

ii. A copy of the Member's Medical Records relating to the ambulance trip, including records from the triage or medical departments, as applicable; and

iii. A copy of the notice of Organization Determination.

d. If the Payment Appeal involves co-payment charges or co-payment reimbursement:

i. A copy of the Member's Medical Records from the corresponding hospital, emergency room, or Provider office;

ii. A copy of utilization records, if the Member was admitted;

iii. A copy of the notification of emergency room visit~~,~~ or admission; and

iv. A copy of the notice of Organization Determination.

6. GARS staff shall request necessary Medical Records using an Authorization for Use or Disclosure of Protected Health Information Form, an Appeal Information Request Form, or Medical Records Request Form.

a. GARS staff may request a Member's Medical Records from any Provider by submitting an Authorization for Use or Disclosure of Protected Health Information Form, or Medical Records Request Form, to such Provider by facsimile labeled with "MEMBER SIGNATURE ON FILE~~"~~," which shall suffice to obtain records for a Member.

b. If a Provider fails to respond to a request for a Member's Medical Records within five (5) calendar days after such request, GARS staff shall notify the Provider Relations Department. If the Provider Relations Department is unable to obtain the Member's Medical Records within five (5) calendar days, the GARS staff shall present the Payment Appeal to the reviewer, as set forth in Section III.E. of this policy, without such Medical Records.

c. If CalOptima cannot obtain all relevant documentation, it shall make a decision based on the material available.

E. Upon verification that the request meets criteria for processing as a Payment Appeal, GARS staff shall send an Acknowledgement Letter, an Authorization for Use and Disclosure of Protected Health Information, and a self-addressed stamped envelope to the Appealing Party who submitted the request for Appeal within five (5) business days after CalOptima receives such request.

~~E.~~F. Payment Appeal Determination

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1. CalOptima shall designate an individual, other than the person involved in making the initial Organization Determination, to review a request for Payment Appeal.

   a. If CalOptima based the original denial on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service, shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

   b. If the request for Appeal involves emergency services, CalOptima shall apply the prudent layperson standard when making the Appeal determination.

2. GARS staff shall present the Payment Appeal to the appropriate reviewer for decision.

3. GARS staff shall document the decision made by the reviewer, including the rationale for the decision.

4. If, upon Payment Appeal, CalOptima completely reverses the adverse Organization Determination, GARS staff shall:

   a. Notify the ~~Member~~Appealing Party of the decision, verbally ~~and~~, no later than one (1) business day from the decision date.

   ~~a.~~b. Notify the Appealing Party of the decision, in writing, ~~with a Notice to Member of Favorable Outcome;~~no later than three (3) calendar days of the verbal notice

   ~~b.~~c. Notify the Claims Department, or the Health Network, of the decision to pay the appealed claim, in accordance with the Provider's contract or the Medicare Fee for Service rates for Providers;

   ~~c.~~d. Verify that payment has been made through the claims system, or that authorization has been issued;

   ~~d.~~e. Ensure that CalOptima~~,~~ or the Health Network~~,~~ adjusts the claim for payment within sixty (60) calendar days after the date of receipt of the request for Appeal;

   ~~e.~~f. Ensure that the Member's case file includes documentation of payment and authorization; and

   ~~f~~g. Note the Payment Appeal as "closed" in the Appeals database.

5. If, upon Appeal, CalOptima affirms, in whole, or in part, the adverse Organization Determination, CalOptima shall take the following actions:

   a. GARS staff shall notify the ~~Member, the Member's Authorized Representative, or Provider~~Appealing Party who requested the Payment Appeal within one (1) business day after CalOptima makes the Appeal determination, but not more than sixty (60) calendar days after receipt of the request for Payment Appeal, ~~including~~and notify the Appealing Party, in writing, within three (3) calendar days of the verbal notice ~~that CalOptima forwarded the Appeal~~. GARS will notify the Member upon forwarding the case to the IRE of the following by using the Model Notice ~~to Member of Unfavorable Outcome;~~of Appeal Status:

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i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

ii. Direct the Member to submit such evidence to the IRE; and

iii. Include information regarding how the Member may contact the IRE.

~~b.~~ GARS staff shall mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file ~~and the Reconsideration Background Data Form and Case Narrative Form with to the IRE within five (5) calendar days of~~ to the IRE, following receipt of CalOptima's Payment Appeal determination, or ~~within~~no later than sixty (60) calendar days after receipt of the request for Appeal~~, whichever is less.~~

b. ~~Within four (4) weeks after CalOptima submits~~. The following should be included in the case file forwarded to the IRE:

i. Appeal Case File Cover Sheet;

ii. Reconsideration Background Date Form (not required if submitting via IRE web portal);

iii. Case Narrative;

iv. Copy of the initial Adverse Organization Determination Request and Notice;

v. Copy of the Appeal Request and Notice;

vi. Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Member, provider, and/or prescriber);

vii. Representation documentation for representative Appeals;

viii. A complete copy of the relevant EOC on a compact disc (CD) (if file is not submitted via IRE web portal); and

ix. Dismissal Case File Data Form.

c. If GARS staff is unable to upload the case files through the IRE QIC Appeals Portal, GARS staff may submit such case files to the IRE by standard mail no later than sixty (60) calendar days after receipt of request for Payment Appeal.

~~c.~~d. Within ten (10) business days of CalOptima's case file submission of a Payment Appeal to the IRE, the GARS Manager~~,~~ or his or her designee~~,~~ shall review ~~the~~such case file to determine if CalOptima received an IRE Acknowledgment Letter to the Member or Provider. If CalOptima did not receive such a letter, GARS staff shall send a letter to the IRE requesting acknowledgment of receipt of the case file using the Letter to the IRE for Acknowledgement of Receipt upon identifying no receipt of the IRE Acknowledgement Letter from the IRE.

6. ~~Independent Review Entity~~Upon an Appealing Party's request, CalOptima shall provide the Appealing Party with a copy of the contents of the Member's case file, including, but not

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limited to, a copy of supporting Medical Records and other pertinent information used to support CalOptima's decision. CalOptima shall provide records at no cost.

~~F.~~G. IRE Determination

1. The IRE will make a decision on an Appeal, in accordance with its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima within a specified timeframe using~~.~~ the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe, using the Request for Information Response Cover Sheet and Request for information Response Letter to IRE.

3. If the IRE upholds CalOptima's adverse Organization Determination, it will notify CalOptima and the Member or the Provider of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Member's Appeal file and update the Appeal tracking system.

4. If the IRE reverses, or partially reverses, CalOptima's determination, GARS staff shall:

   a. Send a ~~Letter~~Notice of Compliance to the Member or Provider~~.~~;

   b. Notify the Member's Provider of the IRE's decision;

   c. Coordinate with the Claims Department, or the Health Network, to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

   d. Send a ~~notification~~notice of compliance ~~letter~~ to the IRE, using the ~~Notice~~Statement of Compliance ~~to IRE~~ Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

   e. Document all activities in the Appeal tracking system.

~~G.~~H. Administrative Law Judge (ALJ) Hearing

1. ~~A Member, a Member's Authorized Representative, or a Provider~~An Appealing Party that provided Covered Services to a Member has the right to a hearing before an ALJ if the projected value of the disputed service meets the appropriate threshold requirement, as set forth in the Medicare Managed Care Manual.

2. ~~A Member, a Member's Authorized Representative, or a Provider~~An Appealing Party shall request an ALJ hearing by submitting such request:

   a. In writing to CalOptima, or the IRE; and

   b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. ~~The Member, the Member's Authorized Representative, or a Provider~~The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Member, the Member's Authorized Representative, or a Provider cannot meet the timeframe, in accordance with Title 20, Code of Federal Regulations, ~~Section~~section 404.911.

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3. If CalOptima receives a request for an ALJ hearing from ~~a Member, a Member's Authorized Representative, or a Provider~~an Appealing Party, GARS staff shall forward the request for an ALJ Hearing to the IRE. The IRE shall compile and forward the Member's file to the ALJ.

4. CalOptima shall not have the right to request an ALJ hearing, but may remain a party to the hearing.

5. If the ALJ reverses CalOptima's adverse Organization Determination, in whole, or in part, CalOptima shall:

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless it requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.H. of this ~~policy~~Policy. If CalOptima requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

   b. Inform the IRE when it effectuates the decision.

~~H.~~I. Medicare Appeals Council (MAC) Review

1. Any party, including CalOptima, that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC review of the ALJ decision or dismissal.

2. A party requesting a MAC review shall submit such request:

   a. In writing directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima receives a Member's, a Member's Authorized Representative's, or a Provider's request for a MAC review, it shall forward a copy of the request for a MAC Hearing, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima requests a MAC Review, it shall:

   a. Submit a request for a MAC Hearing and a complete case file to the MAC;

   b. Concurrently notify the Member or the Provider of CalOptima's request by sending the Member or the Provider a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties, in writing, of its decision to initiate such review.

6. If the MAC reverses CalOptima's initial adverse Organization Determination, in whole, or in part, CalOptima shall:

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a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the adverse Organization Determination; and

b. Inform the IRE when it effectuates the decision.

~~I.~~J. Judicial Review

1. Any party, including CalOptima, may request judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

   b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima, may request judicial review of a MAC decision if:

   a. The MAC denied the party's request for review; or

   b. It is the final decision of CMS; and

   c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

5. CalOptima shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses CalOptima's adverse Organization Determination, in whole, or in part, CalOptima shall:

   a. Pay the disputed claim as directed by the Court, or within sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination if the Court does not specify a time for performance; and

   b. Inform the IRE when it effectuates the decision.

~~J.~~K. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources, including, but not limited to, Grievances, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Board of Directors, with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

~~A. Appointment of Representative Form~~

~~B. Authorization for Release of Protected Health Information (PHI)~~

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~~C. Instruction Sheet for HIPAA Authorization for Release of Protected Health Information~~
~~D. Member Appeal Information Request~~
~~E. Appeal Received After 60 Days Letter~~
~~F. Appeal Acknowledgment Letter~~
~~G. Case Narrative Form Reconsideration Background Data Form~~
~~H. Notice to Member of Favorable Outcome~~
~~I. Notice to Provider of Favorable Outcome~~
~~J. Notice to Member of Unfavorable Outcome~~
~~K. Letter to Independent Review Entity for Acknowledgement of Receipt Independent Review Entity Request for Information Response Cover Letter.~~
~~L. Notice to Member of IRE Compliance~~
~~M. Notice to Independent Review Entity of Compliance~~

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy HH.1104: Complaints of Discrimination~~.~~
C. CalOptima Policy MA.~~9001: Complaint Process~~4002: Cultural and Linguistic Services
D. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
E. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
F. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
G. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
~~E.~~H. Medicare Managed Care Manual, Chapter 13
~~*F. "Change in Part C Reconsideration Dismissal Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/10/2013*~~
I. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
~~G.~~J. Social Security Act, §205(g)
~~H.~~K. Title 20, Code of Federal Regulations (C.F.R.), §404.911
~~I.~~L. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.9005	Payment Appeal	OneCare
Revised	10/01/2012	MA.9005	Payment Appeal	OneCare
Revised	01/01/2014	MA.9005	Payment Appeal	OneCare
Revised	12/01/2016	MA.9005	Payment Appeal	OneCare
Revised	05/01/2017	MA.9005	Payment Appeal	OneCare
Revised	04/01/2022	MA.9005	Payment Appeal	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse initial organization determination made by CalOptima on ~~the~~ health care services ~~a member~~or benefits under Part C the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services ~~(such that~~or drug coverage (when a delay would adversely affect the health of the member), or on any amounts the ~~member~~Member must pay for a service~~.~~ or drug defined in CFR §422.566(b) and §423.566(b). These procedures include reconsideration by ~~CalOptima and if necessary~~, an independent review entity~~, hearings before~~ (IRE), adjudication by an Administrative Law Judges (ALJs), or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.
Appealing Party	For purposes of this Policy, this is a Member, a Member's Authorized Representative, or a Provider (hereinafter "Appealing Party).
Authorized Representative	~~Any individual appointed by a Member, or authorized under state or other applicable law, to act on behalf of a member in an organization or coverage determination, grievance, or appeal.~~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
Explanation of Benefits (EOB)	An ad hoc communication that provides Members with clear and timely information about their medical claims to support informed decisions about their healthcare options.
Grievance	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. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review denial of Coverage Determinations.

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Term	Definition
Medical Records	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.
MemberMembers	An enrollee A beneficiary of aenrolled in the CalOptima OneCare program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Organization Determination	Any determination made by OneCare with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare. 3. OneCare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and/or 5. OneCare's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Payment Appeal	An Appeal involving an Organization Determination regarding payment for services rendered to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Physician Medical Group, or other person or institution who furnishes Covered Services.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form or equivalent written notice.

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Policy:	MA.9005
Title:	**Payment Appeal**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the process by which CalOptima shall ensure that Members have clear and reliable access to a Payment Appeal process that meets the requirements of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima shall establish and maintain a process that addresses the receipt, handling, and disposition of a Payment Appeal, in accordance with applicable statutes, regulations, contractual requirements, and the terms and conditions of this Policy.

B. Grievance and Appeals Resolution Services (GARS) staff shall accept, track, and report all Payment Appeals.

C. Subject to the provisions of this Policy, an Appealing Party may initiate a Payment Appeal.

1. When filing a Payment Appeal on behalf of a Member, a Provider may not charge a fee to the Member for doing so.

D. A Member shall have the right to an attorney, or other representation, in the Payment Appeal process.

E. If a Payment Appeal involves multiple issues, CalOptima shall process each issue separately and simultaneously under the appropriate process.

F. Subject to the provisions of this Policy, CalOptima shall process a Payment Appeal within sixty (60) calendar days after receipt of such Payment Appeal.

G. The processing timeframe for a Payment Appeal shall begin when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) received a Payment Appeal request.

H. CalOptima shall notify a Member of the Payment Appeal process:

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1. Upon initial enrollment, and annually thereafter;

2. In the OneCare Evidence of Coverage and periodic Member newsletters;

3. In all notices of adverse Organization Determination; and

4. Upon the Member's request.

I. Upon request, CalOptima shall provide a Member with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and information used to support CalOptima's Payment Appeal decision.

J. All CalOptima departments shall respond promptly, within designated timeframes, to any inquiry related to a Payment Appeal.

K. CalOptima shall provide all parties to a Payment Appeal with reasonable opportunity to present evidence, or allegations of fact or law, related to the issue in dispute, in person, or in writing. CalOptima shall take all evidence into account when making its decision.

L. CalOptima shall ensure that there is no discrimination against a Member on the grounds that such Member filed a Payment Appeal, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

M. CalOptima shall ensure that Members have equal access to, and can fully participate in, the Payment Appeal process by providing assistance to Members with Limited English Proficiency (LEP), vision disorders, or other communicative impairments in accordance with CalOptima Policy MA.4002: Cultural and Linguistic Services, as follows:

1. Translation of forms and responses;

2. Interpretation services;

3. Telephone relay systems; and

4. Other reasonable accommodations, as appropriate.

III. PROCEDURE

A. Parties to a Payment Appeal

1. An Appealing Party may file a Payment Appeal.

a. A Member may appoint any individual (e.g., relative, friend, advocate, attorney) as his or her Authorized Representative. If an Authorized Representative files a Payment Appeal, he or she shall submit documentation of such appointment, as follows:

i. Appropriate legal documents or authority supporting such appointment; or

ii. An Appointment of Representative Form or equivalent written notice (Representative Form) signed by both the Member and the Member's Authorized Representative, except if an attorney acts as the Member's Authorized Representative. If an attorney acts as the Authorized Representative, the Authorized Representative may submit a Request for

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Appointment of Representative Form or equivalent written notice signed by the Member only.

b. A court acting in accordance with state or other applicable laws can authorize an individual to act on behalf of the Member in filing a Payment Appeal.

i. Authorized Representatives could include, but is not limited to a court appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a health care consent statute, executor of an estate.

ii. The Authorized Representative shall produce and submit appropriate legal papers supporting his or her appointment under state law (a Representative Form is not required).

2. A Non-Contracted Provider, on his, her, or its own behalf, may file an Appeal for a denied claim, in accordance with CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes, if such Non-Contracted Provider:

a. Furnished a Covered Service to a Member; and

b. Completes a Waiver of Liability (WOL) statement that states that the Non-Contracted Provider shall not bill the Member for the Covered Service, regardless of the outcome of the Payment Appeal.

B. Request for Appeal

1. An Appealing Party may request a Payment Appeal verbally, by telephone, in-person with the Customer Service Department, or in writing to CalOptima within sixty (60) calendar days from the date of the receipt of notice of an adverse Organization Determination, or an Explanation of Benefits (EOB).

a. CalOptima may accept a request for Payment Appeal filed after the sixty (60) calendar day limit if the Appealing Party submits a written request for an extension of the timeframe for good cause.

i. In its request for an extension, the Appealing Party must include a statement explaining why the request for Payment Appeal was not filed on time.

ii. If the request for an extension submitted does not include an explanation as to why the request for Payment Appeal was not filed on time, CalOptima may attempt to obtain information supporting good cause for the late filing.

iii. In making its determination, CalOptima should consider the circumstance that kept the party from making the request on time and whether any organization actions may have misled the party.

iv. CalOptima shall ensure that there is no discrimination against a Member in the determination of good cause justification when a Payment Appeal request is outside the sixty (60) calendar day limit, in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

v. Instances where good cause may exist include, but are not limited to:

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a) The Appealing Party either not personally receiving the notice for the adverse initial determination or receiving it late;

b) The Appealing Party was seriously ill which prevented a timely Payment Appeal;

c) Death or serious illness in the Appealing Party's immediate family;

d) An accident causing important records to be destroyed;

e) Difficulty in locating and/or receiving necessary documents within the established time limits;

f) Incomplete or incorrect information regarding the Payment Appeal process;

g) The Appealing Party's lack of capacity to understand the Payment Appeal filing timeframe;

h) The Appealing Party sent the request to an incorrect address, in good faith, within the established time limit;

i) The delay resulted from additional time required to produce Member documents in an accessible format pursuant to CalOptima Policy MA.4002: Cultural and Linguistic Services; or

j) The delay resulted from the Appealing Party having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program or senior center), on account of his or her disability, in order to be able to file the Payment Appeal.

iii. If CalOptima denies the Appealing Party's request for good cause extension, CalOptima must dismiss such request and the Appealing Party may file a Grievance in accordance with CalOptima Policy MA.9002: Member Grievance Process.

2. A Payment Appeal request shall be considered received on the date and time:

a. When any department within CalOptima initially stamps a document received by regular mail;

b. A delivery service (that has the ability to track when a shipment is delivered) delivers the document to CalOptima (or its designee);

c. A faxed document is successfully transmitted to CalOptima, as indicated on the fax transmission report;

d. A verbal request is made by telephone with Customer Service;

e. A message is left on CalOptima's voicemail system (if a voicemail system is utilized to accept the Appeal request or supporting statements after normal business hours); or

f. A Payment Appeal request is received through CalOptima's website.

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3. An Appealing Party who requests a Payment Appeal may withdraw the request at any time before CalOptima renders a decision by notifying CalOptima of such withdrawal, verbally or in writing.

    a. If that party withdraws the Payment Appeal request verbally, CalOptima shall mail that party a written confirmation of the withdrawal to the party within three (3) calendar days from the date of the verbal request.

    b. If the withdrawal request is received after CalOptima has forwarded the case file to the Independent Review Entity (IRE), then CalOptima must forward the withdrawal request to the IRE for processing.

4. Any unit within CalOptima or a delegated entity not responsible for processing Payment Appeals that incorrectly receives a Payment Appeal request, shall submit such request to the CalOptima Grievance and Appeals Resolution Services email inbox: grievancemailbox@caloptima.org, as expeditiously as possible for requests submitted in writing, or transfer to the CalOptima Customer Service Department for verbal requests.

C. Payment Appeal Timeframe

1. Subject to the provisions of this Policy, CalOptima shall make a determination on a Payment Appeal no later than sixty (60) calendar days after receipt of the request for Appeal.

    a. The Payment Appeal processing timeframe begins when CalOptima, any unit within CalOptima, or a delegated entity (including those not responsible for processing the request) receives a Payment Appeal request.

    b. If CalOptima obtains information establishing good cause for filing the Payment Appeal after the 60-day timely filing limit, the adjudication timeframe of the Payment Appeal request begins on the date CalOptima receives that information.

2. If CalOptima fails to provide an Appealing Party who requests a Payment Appeal with a determination within the timeframes specified in Section III.C.1. of this Policy:

    a. CalOptima shall consider such failure as an affirmation of the adverse Organization Determination; and

    b. CalOptima shall forward the request for Payment Appeal to the IRE no later than sixty (60) calendar days after receiving the request for Payment Appeal, in accordance with Sections III.E.5.b.-c.

    c. CalOptima GARS will notify the Appealing Party who requested the Payment Appeal, in writing, that CalOptima forwarded the request to the IRE for final determination by using the model Notice of Appeal Status:

        i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

        ii. Direct the Member to submit such evidence to the IRE; and

        iii. Include information regarding how the Member may contact the IRE.

D. Appeal Processing

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1. Upon receipt of a request for Appeal, GARS staff shall:

    a. Date stamp, and code the request with the appropriate categorization in the database; and

    b. Prepare a case file that contains the original request for a Payment Appeal, notice of CalOptima's or a Health Network's adverse Organization Determination, and all other correspondence.

2. If a Member makes a verbal Payment Appeal, GARS staff shall request confirmation of such as follows:

    a. GARS staff shall confirm with the party receiving the verbal Payment Appeal that he or she verified with the Appealing Party the facts and basis of the request for Payment Appeal. The validated verbal acknowledgement shall be documented in the CalOptima database.

    b. GARS staff shall send an Acknowledgement Letter for verbal Payment Appeal requests to the Member to confirm the facts and basis of the Payment Appeal to ensure the request is properly and accurately noted and addressed by CalOptima. Notice should advise the Member to contact CalOptima if the Acknowledgement Letter does not correctly capture the Member's request.

3. GARS staff shall verify that the request meets criteria for processing as a Payment Appeal:

    a. GARS staff shall verify that the requestor is a Member a Member's Authorized Representative, or a Provider. If the requestor is not one of these parties, GARS staff shall request in writing, that the requestor submit documentation of the requestor's status as the Member's Authorized Representative. Included with the request, staff shall send an Appointment of Representative Form and an Authorization for Use and Disclosure of Protected Health Information Form to avoid delays for a Payment Appeal determination.

        i. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative, GARS staff shall:

            a) Make and document at least two (2) telephone calls to the requestor in an attempt to obtain documentation.

            b) Inform the Member and purported representative, in writing, that CalOptima will not issue a decision for the Payment Appeal request until valid documentation is provided.

        ii. If CalOptima does not receive documentation of the requestor's status as the Member's Authorized Representative no later than sixty (60)calendar days after CalOptima's receipt of the Payment Appeal:

            a) CalOptima shall dismiss the Payment Appeal and notify the Member, in writing, that the request for Appeal shall be dismissed due to lack of the required documentation to process the request using the Notice of Dismissal of Appeal Request.

                1) The dismissal would be no sooner than sixty (60) calendar days after receipt of the Payment Appeal.

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2) The dismissal notice shall inform the Member of the process and his or her right to request a review of the dismissal by an Independent Review Entity (IRE), in which, such request must be filed within sixty (60) calendar days from the date of receipt of CalOptima written dismissal notice.

b. GARS staff shall verify if CalOptima or a Health Network denied a claim for payment.

i. If CalOptima or a Health Network did not process the claim, GARS staff shall transmit the claim to the Claims Department or the Health Network for processing and shall notify the Appealing Party who requested the Appeal, of CalOptima's claims processing and Organization Determination process.

ii. If CalOptima or a Health Network did not deny the claim, GARS staff shall determine if the Member disputes a cost-sharing determination, or if the Provider who requests an Appeal disputes the payment amount.

c. GARS staff shall review the notice of adverse Organization Determination to verify that CalOptima received the request for Appeal within sixty-five (65) calendar days after the date of notice. If CalOptima received the request later than sixty-five (65) calendar days after the date of notice, GARS staff shall provide written notice, using the Over Sixty (60) Days Letter, to the Appealing Party who requested the Appeal. The notice shall inform the Appealing Party that the request does not meet criteria for Appeal unless the requesting party provides good cause for an extension, in accordance with Section III.B.1.b.i-ii. of this Policy.

4. If GARS staff identifies a potential quality of care issue, he or she shall forward a referral to the Quality Improvement (QI) Department, in accordance with CalOptima Policy MA.9002: Member Grievance Process.

5. GARS staff shall prepare the case file with appropriate information and documents that include, but are not limited to, the following:

a. A copy of the Member's eligibility status.

b. If the Payment Appeal involves a denied hospital claim, including emergency room claims:

i. A copy of the Member's Medical Records;

ii. A copy of the notification of admission; and

iii. A copy of the notice of Organization Determination.

c. If the Payment Appeal involves a denied ambulance claim:

i. A copy of the transport record;

ii. A copy of the Member's Medical Records relating to the ambulance trip, including records from the triage or medical departments, as applicable; and

iii. A copy of the notice of Organization Determination.

d. If the Payment Appeal involves co-payment charges or co-payment reimbursement:

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i. A copy of the Member's Medical Records from the corresponding hospital, emergency room, or Provider office;

ii. A copy of utilization records, if the Member was admitted;

iii. A copy of the notification of emergency room visit or admission; and

iv. A copy of the notice of Organization Determination.

6. GARS staff shall request necessary Medical Records using an Authorization for Use or Disclosure of Protected Health Information Form, an Appeal Information Request Form, or Medical Records Request Form.

a. GARS staff may request a Member's Medical Records from any Provider by submitting an Authorization for Use or Disclosure of Protected Health Information Form, or Medical Records Request Form, to such Provider by facsimile labeled with "MEMBER SIGNATURE ON FILE," which shall suffice to obtain records for a Member.

b. If a Provider fails to respond to a request for a Member's Medical Records within five (5) calendar days after such request, GARS staff shall notify the Provider Relations Department. If the Provider Relations Department is unable to obtain the Member's Medical Records within five (5) calendar days, the GARS staff shall present the Payment Appeal to the reviewer, as set forth in Section III.E. of this policy, without such Medical Records.

c. If CalOptima cannot obtain all relevant documentation, it shall make a decision based on the material available.

E. Upon verification that the request meets criteria for processing as a Payment Appeal, GARS staff shall send an Acknowledgement Letter, an Authorization for Use and Disclosure of Protected Health Information, and a self-addressed stamped envelope to the Appealing Party who submitted the request for Appeal within five (5) business days after CalOptima receives such request.

F. Payment Appeal Determination

1. CalOptima shall designate an individual, other than the person involved in making the initial Organization Determination, to review a request for Payment Appeal.

a. If CalOptima based the original denial on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service, shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

b. If the request for Appeal involves emergency services, CalOptima shall apply the prudent layperson standard when making the Appeal determination.

2. GARS staff shall present the Payment Appeal to the appropriate reviewer for decision.

3. GARS staff shall document the decision made by the reviewer, including the rationale for the decision.

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4. If, upon Payment Appeal, CalOptima completely reverses the adverse Organization Determination, GARS staff shall:

    a. Notify the Appealing Party of the decision, verbally, no later than one (1) business day from the decision date.

    b. Notify the Appealing Party of the decision, in writing, no later than three (3) calendar days of the verbal notice

    c. Notify the Claims Department, or the Health Network, of the decision to pay the appealed claim, in accordance with the Provider's contract or the Medicare Fee for Service rates for Providers;

    d. Verify that payment has been made through the claims system, or that authorization has been issued;

    e. Ensure that CalOptima or the Health Network adjusts the claim for payment within sixty (60) calendar days after the date of receipt of the request for Appeal;

    f. Ensure that the Member's case file includes documentation of payment and authorization; and

    g. Note the Payment Appeal as "closed" in the Appeals database.

5. If, upon Appeal, CalOptima affirms, in whole, or in part, the adverse Organization Determination, CalOptima shall take the following actions:

    a. GARS staff shall notify the Appealing Party who requested the Payment Appeal within one (1) business day after CalOptima makes the Appeal determination, but not more than sixty (60) calendar days after receipt of the request for Payment Appeal, and notify the Appealing Party, in writing, within three (3) calendar days of the verbal notice. GARS will notify the Member upon forwarding the case to the IRE of the following by using the Model Notice of Appeal Status:

        i. Advise the Member of his or her rights to submit additional evidence that may be pertinent to the Member's case;

        ii. Direct the Member to submit such evidence to the IRE; and

        iii. Include information regarding how the Member may contact the IRE.

    b. GARS staff shall mail or submit through the IRE Quality Independent Contractor (QIC) Appeals web portal, a copy of the case file to the IRE, following receipt of CalOptima's Payment Appeal determination, or no later than sixty (60) calendar days after receipt of the request for Appeal. The following should be included in the case file forwarded to the IRE:

        i. Appeal Case File Cover Sheet;

        ii. Reconsideration Background Date Form (not required if submitting via IRE web portal);

        iii. Case Narrative;

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iv. Copy of the initial Adverse Organization Determination Request and Notice;

v. Copy of the Appeal Request and Notice;

vi. Copy of information used to make Appeal decision, including supporting documentation (e.g., medical records, or evidence submitted by the Member, provider, and/or prescriber);

vii. Representation documentation for representative Appeals;

viii. A complete copy of the relevant EOC on a compact disc (CD) (if file is not submitted via IRE web portal); and

ix. Dismissal Case File Data Form.

c. If GARS staff is unable to upload the case files through the IRE QIC Appeals Portal, GARS staff may submit such case files to the IRE by standard mail no later than sixty (60) calendar days after receipt of request for Payment Appeal.

d. Within ten (10) business days of CalOptima's case file submission of a Payment Appeal to the IRE, the GARS Manager or his or her designee shall review such case file to determine if CalOptima received an IRE Acknowledgment Letter to the Member or Provider. If CalOptima did not receive such a letter, GARS staff shall send a letter to the IRE requesting acknowledgment of receipt of the case file using the Letter to the IRE for Acknowledgement of Receipt upon identifying no receipt of the IRE Acknowledgement Letter from the IRE.

6. Upon an Appealing Party's request, CalOptima shall provide the Appealing Party with a copy of the contents of the Member's case file, including, but not limited to, a copy of supporting Medical Records and other pertinent information used to support CalOptima's decision. CalOptima shall provide records at no cost.

G. IRE Determination

1. The IRE will make a decision on an Appeal, in accordance with its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima within a specified timeframe using the IRE Request for Additional Information Form. Upon receipt of such request, GARS staff shall make every effort to provide the requested information within the specified timeframe, using the Request for Information Response Cover Sheet and Request for information Response Letter to IRE.

3. If the IRE upholds CalOptima's adverse Organization Determination, it will notify CalOptima and the Member or the Provider of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the Member's Appeal file and update the Appeal tracking system.

4. If the IRE reverses, or partially reverses, CalOptima's determination, GARS staff shall:

a. Send a Notice of Compliance to the Member or Provider;

b. Notify the Member's Provider of the IRE's decision;

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c. Coordinate with the Claims Department, or the Health Network, to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

d. Send a notice of compliance to the IRE, using the Statement of Compliance Form within fourteen (14) calendar days after authorization, or provision of the disputed service; and

e. Document all activities in the Appeal tracking system.

H. Administrative Law Judge (ALJ) Hearing

1. An Appealing Party that provided Covered Services to a Member has the right to a hearing before an ALJ if the projected value of the disputed service meets the appropriate threshold requirement, as set forth in the Medicare Managed Care Manual.

2. An Appealing Party shall request an ALJ hearing by submitting such request:

a. In writing to CalOptima, or the IRE; and

b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The Appealing Party may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the Member, the Member's Authorized Representative, or a Provider cannot meet the timeframe, in accordance with Title 20, Code of Federal Regulations, section 404.911.

3. If CalOptima receives a request for an ALJ hearing from an Appealing Party, GARS staff shall forward the request for an ALJ Hearing to the IRE. The IRE shall compile and forward the Member's file to the ALJ.

4. CalOptima shall not have the right to request an ALJ hearing, but may remain a party to the hearing.

5. If the ALJ reverses CalOptima's adverse Organization Determination, in whole, or in part, CalOptima shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless it requests Medicare Appeals Council (MAC) review of the ALJ decision, in accordance with Section III.H. of this Policy. If CalOptima requests MAC review of the ALJ decision, it may wait for the MAC's decision before it authorizes, or provides, the disputed service; and

b. Inform the IRE when it effectuates the decision.

I. Medicare Appeals Council (MAC) Review

1. Any party, including CalOptima, that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC review of the ALJ decision or dismissal.

2. A party requesting a MAC review shall submit such request:

a. In writing directly to the MAC; and

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b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima receives a Member's, a Member's Authorized Representative's, or a Provider's request for a MAC review, it shall forward a copy of the request for a MAC Hearing, the Member's complete case file, and a cover letter to the MAC.

4. If CalOptima requests a MAC Review, it shall:

   a. Submit a request for a MAC Hearing and a complete case file to the MAC;

   b. Concurrently notify the Member or the Provider of CalOptima's request by sending the Member or the Provider a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC will notify all parties, in writing, of its decision to initiate such review.

6. If the MAC reverses CalOptima's initial adverse Organization Determination, in whole, or in part, CalOptima shall:

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

J. Judicial Review

1. Any party, including CalOptima, may request judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

   b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima, may request judicial review of a MAC decision if:

   a. The MAC denied the party's request for review; or

   b. It is the final decision of CMS; and

   c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States, in accordance with Section 205(g) of the Social Security Act.

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5. CalOptima shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses CalOptima's adverse Organization Determination, in whole, or in part, CalOptima shall:

   a. Pay the disputed claim as directed by the Court, or within sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination if the Court does not specify a time for performance; and

   b. Inform the IRE when it effectuates the decision.

K. Appeals Data

1. The Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources, including, but not limited to, Grievances, Member satisfaction survey results, and disenrollment forms.

2. The QIC shall present aggregate information to the CalOptima Board of Directors, with recommendations for interventions, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy HH.1104: Complaints of Discrimination
C. CalOptima Policy MA.4002: Cultural and Linguistic Services
D. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
E. Health Plan Management System (HPMS) Notice September 10, 2013, Change in Part C Reconsideration Dismissal Procedures
F. MAXIMUS Appendix: Reconsideration Case Forms and Instructions
G. MAXIMUS Federal Medicare Health Plan Reconsideration Process Manual
H. Medicare Managed Care Manual, Chapter 13
I. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
J. Social Security Act, §205(g)
K. Title 20, Code of Federal Regulations (C.F.R.), §404.911
L. Title 42, Code of Federal Regulations (C.F.R.), §422.560 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.9005	Payment Appeal	OneCare
Revised	10/01/2012	MA.9005	Payment Appeal	OneCare
Revised	01/01/2014	MA.9005	Payment Appeal	OneCare
Revised	12/01/2016	MA.9005	Payment Appeal	OneCare
Revised	05/01/2017	MA.9005	Payment Appeal	OneCare
Revised	04/01/2022	MA.9005	Payment Appeal	OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Any of the procedures that deal with the review of an adverse initial organization determination made by CalOptima on health care services or benefits under Part C 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 defined in CFR §422.566(b) and §423.566(b). These procedures include reconsideration by, an independent review entity (IRE), adjudication by an Administrative Law Judges (ALJs), or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. A reconsideration (Part C) consists of a review of an adverse initial determination, the evidence and finding upon which it was based, and any other evidence that the parties submit or that is obtained by the plan.
Appealing Party	For purposes of this Policy, this is a Member, a Member's Authorized Representative, or a Provider (hereinafter "Appealing Party).
Authorized Representative	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
Explanation of Benefits (EOB)	An ad hoc communication that provides Members with clear and timely information about their medical claims to support informed decisions about their healthcare options.
Grievance	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. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review denial of Coverage Determinations.
Medical Records	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 the CalOptima OneCare program.

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Term	Definition
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Organization Determination	Any determination made by OneCare with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare. 3. OneCare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and/or 5. OneCare's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Payment Appeal	An Appeal involving an Organization Determination regarding payment for services rendered to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, or other person or institution who furnishes Covered Services.
Representative Form	For purposes of this Policy, a term used to collectively refer to an Appointment of Representative Form or equivalent written notice.

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Policy:	MA.9009
Title:	**Non-Contracted Provider Payment ~~Disputes~~Appeals**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2010
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima ensures that Non-Contracted Providers (NCP) have clear and reliable access to ~~a Provider Payment Dispute Resolution (PDR) and~~an Appeal process that meets the requirement of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima and Health Networks shall establish and maintain a process that addresses the receipt, handling, and disposition of ~~a PDR~~an Appeal for NCPs in accordance with applicable statutes, regulations, contractual requirements, and the terms and conditions of this policy.

~~B. The CalOptima Claims Administration Department and Health Network staff shall accept, track, and report all NCP PDRs as determined by CalOptima's Audit & Oversight Department.~~

~~C. NCPs may file a PDR within one hundred and eighty (180) calendar days from the receipt of the Remittance Advice (RA) for level of payment disputes. (The notice of initial determination is presumed to be received five (5) calendar days from the date of the RA unless there is evidence to the contrary).~~

~~D.~~B. CalOptima and Health Networks shall provide all parties to ~~a PDR~~an Appeal with reasonable opportunity to present evidence, or allegations, of fact, or law, related to the issue in dispute in ~~person, or in~~ writing. CalOptima shall take all evidence into account when making its decision.

~~E.~~C. The CalOptima Claims Administration Department and Health Networks shall process ~~PDRs~~Provider Payment Dispute Resolutions (PDRs) involving payment disputes regarding payment being less than that paid by Medicare fee-for-service, ~~or payment for a different service than billed,~~ within ~~thirty (30) calendar~~forty-five (45) business days after receipt of such PDR~~, in accordance with this policy.~~.

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~~F.~~D. In the case of a PDR, CalOptima's Claims Administration Department and Health Networks shall inform the NCP in the notice of PDR decision of his or her right to file a complaint with CalOptima, in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

~~G.~~E. CalOptima ~~Grievance~~ and ~~Appeals Resolution Services (GARS) Department~~the Health Networks shall process all NCP claims payment disputes ~~with zero (0) payment~~ as Appeals, ~~including those received by CalOptima's Claims Administration Department and Health Networks,~~ within sixty (60) calendar days of receipt of the Waiver of Liability (WOL) form. NCP claims payment disputes can constitute any organization determination that leads to a fully or partially adverse determination. Organization determinations include, but are not limited to the following situations:

1. A reopening, which leads to a fully or partially adverse determination;

2. Diagnosis code/DRG payment denials: An NCP submits a claim to CalOptima. CalOptima initially approves the claim, which is considered a favorable organization determination (pursuant to Title 42 Code of Federal Regulations (CFR), section 422.566(b)). CalOptima later reopens and revises the favorable organization determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds;

3. Downcoding: CalOptima approves coverage for inpatient services from a NCP, which is considered a favorable organization determination (pursuant to Title 42, CFR section 422.566(b)). CalOptima later reopens and revises the favorable organization determination (e.g., retrospective review) and determines the Member should have received outpatient services; and

4. Bundling issues and disputed rate of payment: Pre- and post-pay bundling and global payment determinations. For example, denial of procedure codes – as mutually exclusive to another, or due to inclusion in a previously paid global surgical package.

5. Level of care or rate of payment denials: Payment of a reduced fee schedule amount for a course treatment. For example, a provider bills a procedure code for a visit, but CalOptima reimburses based on a lower level of care.

~~H.~~F. NCPs may file an Appeal with the CalOptima Grievance and Appeal Resolution Services (GARS) Department or the Health Network, within sixty (60) calendar days from the receipt of the Remittance Advice (RA) for ~~zero (0)~~all payment disputes~~. The notice~~, notwithstanding PDRs as described in Section II.D. of ~~initial determination is presumed to be received five (5) calendar days from the date of the RA unless evidence shows otherwise~~this Policy.

~~I.~~G. CalOptima and the Health Networks shall notify an NCP of the ~~PDR and~~ Appeal process:

1. In all RAs;

2. On the CalOptima Website at www.caloptima.org-; and

3. Upon request by the NCP.

III. PROCEDURE

A. Submission of ~~PDR~~an Appeal request involving Claims payment dispute:

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1. An NCP shall submit the initial payment dispute, in writing, within the required ~~time frame~~timeframe using the Provider ~~Dispute~~Complaint Resolution Request ~~Form~~or a letter and shall include:

   i. The Member's name;

   ii. Medicare ~~health insurance~~Beneficiary Identifier (MBI) (formally known as Medicare Health Insurance Claim (HIC) number) or Client Index Number (CIN);

   iii. The specific service(s) and/or items(s) for which the ~~PDR~~Appeal is being requested;

   iv. The specific date(s) of the service;

   v. Copy of the original claim or remittance notification showing the denial;

   ~~v.~~vi. The name and signature of the party or the representative of the party filing the request; ~~and~~

   vii. A Waiver of Liability Form; and

   ~~vi.~~viii. Any additional information that supports the request, including, but not limited to, Medical Records.

2. ~~CalOptima's Claims Administration Department, CalOptima~~ or a Health Network~~,~~ shall notify the Provider if any required information as stated in Section III.A.1. of this ~~policy~~Policy is missing. If the information is not submitted within the required ~~time frame~~timeframe, CalOptima shall process the ~~dispute~~Appeal in accordance with Sections III.B~~.~~., and III.C. of this ~~policy~~Policy.

B. For a PDR handled by a ~~CalOptima~~ Health Network~~,~~ or CalOptima Claims Administration Department:

1. ~~Disputes related to the amount of~~For disputes for a payment~~, or payment for services different~~ less than ~~billed (down coding),~~that paid by Medicare fee-for-service, the NCP shall file the dispute with the payer as identified on the RA, either the Health Network~~,~~ or CalOptima Claims Administration Department.

   a. Contact information for Health Networks is available on the CalOptima website at ~~www.caloptima.org~~www.caloptima.org, or by contacting CalOptima's Health Network Relations Department at 714-246-8600.

   b. Claims processed by CalOptima Claims Administration Department, mail to:

   CalOptima Claims Department— Provider Dispute Unit
   P.O. Box ~~1106~~57015
   ~~Orange~~Irvine, CA ~~92856-8165~~92619

C. CalOptima's Claims Administration Department and the Health Network shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request.

1. ~~A~~An NCP may file a complaint with CalOptima, in accordance with CalOptima Policy MA.9006: Provider Complaint Process~~, if the NCP is not satisfied with the decision issued by the Health Network, or CalOptima Claims Administration Department; or a decision is not~~

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~~issued by the Health Network, or CalOptima Claims Administration Department, within the thirty (30) calendar day time limit.~~:

a. If the NCP is not satisfied with the decision issued by the Health Network or CalOptima Claims Administration Department; or

b. A decision is not issued by the Health Network or CalOptima Claims Administration Department within the one hundred and eighty (180) calendar day time limit.

D. For an Appeal handled by CalOptima GARS ~~(~~or a Health Network, such Appeals are payment disputes ~~related to claims with zero (0) payment):~~from NCP Medicare providers, that are not PDRs:

1. File the request, in writing, within sixty (60) calendar days from the notice of denial with CalOptima GARS ~~at:~~or the Health Network, based on the payer on the RA.

~~CalOptima Grievance and Appeals~~
~~505 City Parkway West~~
~~Orange, CA 92868~~

2. The NCP may request an extension to this ~~time frame~~timeframe for good cause by submitting a written request for such an extension that includes the reason the NCP cannot meet the ~~time frame~~timeframe, in accordance with Title 20 ~~of the Code of Federal Regulations, Section~~CFR, section 404.911.

3. Upon verification that the request meets criteria for processing as an Appeal, CalOptima GARS ~~staff~~or the Health Network shall send ~~a~~an NCP an acknowledgement letter and a WOL form, if not already included with the Appeal request, ~~within five (5) business days~~ after ~~CalOptima receives~~receipt of the Appeal request.

4. If the NCP fails to submit a signed WOL form after three (3) attempts (written and ~~two (2)~~ verbal requests) by CalOptima GARS ~~Department~~or the Health Network, the GARS Department or the Health Network shall notify the NCP that the request shall be dismissed due to lack of the WOL, no sooner than sixty (60) calendar days from the receipt of the request. The Notice of Dismissal of Appeal Request shall inform the NCP of the process and the right to request a review of the dismissal by the Independent Review Entity (IRE).

5. CalOptima GARS or the Health Network shall commence review of the Appeal upon receipt of the signed WOL form or letter of good cause, as applicable, and the review shall be completed within sixty (60) calendar days of that the receipt date.

6. Upon completion of review of the Appeal, GARS or the Health Network shall send a resolution letter to the NCP informing the NCP of the review decision within sixty (60) calendar days of receipt of the signed WOL form.

7. Failure of CalOptima GARS or the Health Network to provide the NCP with a decision within the sixty (60) calendar day period constitutes an adverse decision and GARS or the Health Network shall forward the ~~appeal~~Appeal to the IRE for review.

8. An Appeal decision which upholds in whole, or in part, the initial denial shall be forwarded to the IRE for review.

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~~3. CalOptima's GARS and Claims Administration Departments and the Health Networks shall document all actions taken related to the PDR, or Appeal, request in its tracking system and/or hard copy including, but not limited to:~~

~~1. Provider's name;~~

~~2. Date received;~~

~~3. Name of staff that received the complaint at CalOptima;~~

~~4. Designated contact person;~~

~~5. Description of the complaint;~~

~~6. Date; and~~

~~7. Disposition.~~

E. Appeal Review

1. CalOptima or the Health Network shall designate an individual other than the person involved in making the initial Organization Determination to review a request for Appeal.

   a. If the original denial is based on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

   b. If the request for Appeal involves Emergency Services, CalOptima shall apply the Prudent Layperson Standard when reviewing the Appeal.

2. GARS staff or the Health Network shall present the Appeal request to the appropriate reviewer for decision.

3. CalOptima GARS or the Health Network shall document the decision made by the reviewer, the rationale for the decision, and include the ~~signature~~name of the staff who reviewed the case in ~~the "Plan Reconsideration Decision" section included with the Reconsideration Background Data Form.~~a Provider resolution letter.

4. If, upon the Appeal review, CalOptima or the Health Network completely reverses its adverse Organization Determination, GARS staff or the Health Network shall:

   a. Notify the Provider of the decision, in writing;

   b. Notify ~~the~~ and request claim payment from CalOptima ~~Claims Administration Department,~~ or the Health Network~~, in writing, of the decision to pay the Appealed claim~~ Claims Department;

   c. Verify that CalOptima~~,~~ or the Health Network~~,~~ made payment through the claims system~~,~~ and/or that a retro-authorization was issued;

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d. Ensure that CalOptima~~,~~ or the Health Network~~,~~ adjusts claims for payment within sixty (60) calendar days after the date of receipt of the request for Appeal;

e. Ensure that the NCP's case file includes documentation of payment~~, or~~ and retro-authorization, if required; and

f. Note the Appeal as "closed" in the Appeals database.

5. If, upon Appeal review, CalOptima or the Health Network affirms, in whole, or in part, the adverse Organization Determination, CalOptima or the Health Network shall take the following actions:

a. ~~CalOptima GARS staff shall notify~~ Notify the NCP who requested the Appeal ~~within one (1) business day after CalOptima makes the Appeal decision, but not more~~no later than sixty (60) calendar days after receipt of the signed WOL, including notice that CalOptima or the Health Network forwarded the Appeal to the IRE.

b. ~~CalOptima GARS staff shall mail~~Forward a copy of the case file, and the Reconsideration Background Data Form and Case Narrative Form to the IRE ~~within five (5~~, no later than sixty (60) calendar days ~~after CalOptima makes the Appeal decision.~~of receipt of the signed WOL. The Health Network should notify CalOptima of submission to the IRE simultaneously with submission.

F. IRE Determination

1. The IRE shall make a decision on an Appeal in accordance with its CMS contracted ~~time frame~~timeframe.

2. The IRE may request additional information from CalOptima or the Health Network within a specified ~~time frame~~timeframe using the IRE Request for Additional Information Form. Upon receipt of such request, CalOptima GARS staff or the Health Network shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Letter to IRE. The Health Network should notify CalOptima of any additional submissions to the IRE at the time of submission to the IRE.

3. If the IRE upholds CalOptima's or the Health Network's adverse Organization Determination, it shall notify CalOptima or the Health Network and the NCP of such decision, in writing. Upon receipt of such notice, GARS staff or the Health Network shall place the notice in the NCP's Appeal file. The Health Network should notify CalOptima of the final decision by the IRE within five (5) calendar days of notification.

4. If the IRE reverses~~,~~ or partially reverses~~,~~ CalOptima's or the Health Network's adverse Organization Determination, CalOptima GARS or the Health Network shall:

a. Coordinate with the CalOptima Claims ~~Administrtion~~Administration Department to arrange for the payment~~,~~ or adjustment~~,~~ of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

b. Coordinate with the Health Network's Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than twenty (20) calendar days after notice from the IRE;

~~b.~~c. Notify the NCP of the IRE's decision and compliance with IRE decision;

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~~e.~~d. Send a notification of compliance letter to the IRE; and

~~d.~~e. Document all activities in the Appeal tracking system.

5. The Health Network shall notify CalOptima of the final decision by the IRE, with proof of effectuation within twenty (20) calendar days of notification.

G. Administrative Law Judge (ALJ) Hearing

1. An NCP that provided Covered Services to a Member has the right to a hearing before an ALJ if the projected value of the disputed service meets the threshold amount specified in the Medicare Managed Care Manual, as determined by Medicare regulations and the ALJ.

2. An NCP shall request an ALJ hearing by submitting such request:

   a. In writing to CalOptima, or the IRE; and

   b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The NCP may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the NCP cannot meet the timeframe in accordance with Title 20 ~~of the Code of Federal Regulations, Section 404~~CFR, section 404.911.

3. If CalOptima receives a request for an ALJ hearing from an NCP, CalOptima GARS staff shall forward the Provider request for ALJ hearing to the IRE. The IRE shall compile and forward the NCP's file to the ALJ.

4. ~~CalOptima~~If the Health Network receives a request for an ALJ hearing from an NCP, the Health Network shall forward the Provider request for ALJ hearing to the IRE with a Carbon Copy to CalOptima. The IRE shall compile and forward the NCP's file to the ALJ.

~~4.~~5. CalOptima or the Health Network shall not have the right to request an ALJ hearing, but may remain a party to the hearing.

~~5.~~6. If the ALJ reverses CalOptima's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima shall:

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless it requests Medicare Appeals Council (MAC) review of the ALJ decision in accordance with Section III.H. of this ~~policy. If CalOptima requests~~Policy.

   b. Request a MAC ~~review~~Hearing of the ALJ decision~~, CalOptima may wait~~; and

   ~~a.~~c. Wait for the MAC's decision before it authorizes, or provides, the disputed service; and

   ~~b.~~d. Inform the IRE when it effectuates the decision.

H. Medicare Appeals Council (MAC) Review

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1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC ~~review~~Hearing of the ALJ decision, or dismissal.

2. A party requesting a MAC ~~review~~Hearing shall submit such request:

   a. In writing, directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima receives an NCP's request for a MAC ~~review~~Hearing, it shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to the MAC.

4. If the Health Network receives an NCP's request for a MAC Hearing, it shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to CalOptima within five (5) days of receipt.

~~4.~~5. If CalOptima requests a MAC ~~Review~~Hearing, it shall:

   a. Submit a CalOptima Request for MAC Hearing and a complete case file to the MAC;

   b. Concurrently notify the NCP of CalOptima's request by sending the Provider a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC shall notify all parties, in writing, of its decision to initiate such review.

6. If the MAC reverses CalOptima's or the Health Networks' initial adverse Organization Determination in whole, or in part, CalOptima or the Health Network shall:

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima~~,~~ may request a judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

   b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima, may request a judicial review of a MAC decision if:

   a. The MAC denied the party's request for review; or

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b. It is the final decision of CMS; and

c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain a judicial review unless the MAC has acted on the case.

4. In order to obtain a judicial review, a party shall file a civil action in a district court of the United States in accordance with Section 205(g) of the Social Security Act.

5. CalOptima shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses CalOptima's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima or a Health Network shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and

b. Inform the IRE when it effectuates the decision.

J. Documentation of Data

1. CalOptima's GARS and Claims Administration ~~Department~~Departments and Health Networks shall document all actions taken related to ~~the PDR, or~~an Appeal~~,~~ request in its tracking system and/or hard copy including, but not limited to:

a. Provider's name;

b. Date received;

c. Name of staff that received the complaint at CalOptima;

d. Designated contact person;

e. Description of the complaint;

f. Date; and

g. Disposition.

~~**IV. CalOptima's Quality Improvement Committee (QIC) shall track, trend, and analyze Appeals data, taking into account information from other sources including, but not limited to, Grievances, Health Network reports, Member satisfaction survey results, and disenrollment forms.**~~

~~**V.**~~

~~**VI. The QIC shall present aggregate information to CalOptima's Board of Directors with recommendations for interventions, as appropriate.**~~

~~**VII.**~~

IV. ATTACHMENT(S)

Not Applicable

~~A. CalOptima Provider Dispute Request Form~~

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~~B. Waiver of Liability Statement (OneCare)~~
~~C. Waiver of Liability Statement (OneCare Connect)~~
~~D. Notice of Dismissal of Appeal Request (OneCare)~~
~~E. Notice of Dismissal of Appeal Request (OneCare Connect)~~

~~VIII.~~V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.A. CalOptima Policy MA.9006: Provider Complaint Process~~
~~C.~~B. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and the Centers for Medicaid and Medicare Services (CMS) for Cal MediConnect
C. CalOptima Policy MA.9006: Provider Complaint Process
D. Centers for Medicare & Medicaid Services Letter, Provider Payment Dispute Resolution for Non-Contracted Providers, January 4, 2010
~~E. MA Payment Guide for Out of Network Payments, Revised September 27, 2013~~
~~F. MAXIMUS Medicare Health Plan Reconsideration Process Manual~~
~~G.A. "Model Dismissal Notice," Health Plan Management System (HPMS) Memorandum, Issued October 30, 2013~~
~~H. "Non-Contract Provider Payment Dispute Program," Health Plan Management System (HPMS) Memorandum, Issued December 20, 2013~~
~~I.~~E. "Part C Dismissals Procedure," Health Plan Management System (HPMS) Memorandum, Issued September 10, 2013
F. "Model Dismissal Notice," Health Plan Management System (HPMS) Memorandum, Issued October 30, 2013
G. MA Payment Guide for Out of Network Payments, Revised April 15, 2015
~~J.~~H. MAXIMUS Medicare ~~Managed Care~~Health Plan Reconsideration Process Manual, ~~Chapter 13~~Revised January 2020
I. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Revised January 2020
J. "Non-Contract Provider Access to Medicare Administrative Appeals Process," Health Plan Management System (HPMS) Memorandum, Issued September 23, 2020
K. Social Security Act, §§1852(k) and 1894(b)(3)
L. Title 20, Code of Federal Regulations (C.F.R.), § 404.911.
M. Title 20, California Code of Regulations (C.C.R.), §§ 1300.71 and 1300.71.38.
~~L.~~N. Title 42, Code of Federal Regulations (C.F.R.), §§417.588, 422.214, 422.520, 422.560, 422.566(b) et. seq.

~~IX.~~VI. REGULATORY AGENCY ~~APPROVALS~~APPROVAL(S)

None to Date

~~X.~~VII. BOARD ~~ACTIONS~~ACTION(S)

~~None to Date~~

Date	Meeting

~~XI.~~VIII. ~~REVIEW/~~REVISION HISTORY

For 20220505 BOD Review for Ratification

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	01/01/2010	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	03/01/2012	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	01/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	03/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	01/01/2015	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	01/01/2017	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	04/01/2022	MA.9009	Non-Contracted Provider Payment Appeals	OneCare OneCare Connect

For 20220505 BOD Review for Ratification

~~XII.~~IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse ~~organization~~initial determination made by CalOptima on ~~the~~ health care services ~~a member~~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 ~~(such that~~or drug coverage (when a delay would adversely affect the health of the ~~member~~Member), or on any amounts the ~~member~~Member must pay for a service~~.~~ or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration ~~by CalOptima and if necessary,~~ or redetermination, a reconsideration by an independent review entity~~, hearings before (IRE), adjudication by an~~ Administrative Law ~~Judges (ALJs),~~Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. ~~A Non-Contracted Provider may Appeal a denied claim.~~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.
Covered Services	Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish ~~emergency services~~Emergency Services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review ~~Medicare health plans' adverse Appeal decisions.~~ denial of Coverage Determinations.
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.

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Term	Definition
Medically Necessary/Medical Necessity	OneCare: ~~Necessary~~The services ~~to protect life, to prevent significant illness~~, supplies, or ~~significant disability, or to alleviate severe pain through~~drugs that are needed for the prevention, diagnosis, or ~~Treatment~~treatment of ~~disease, illness, or injury~~your medical condition and meet accepted standards of medical practice. 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 ~~Enrollee~~Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Non-Contracted Provider (NCP)	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Organization Determination	Any determination made by ~~OneCare or~~ OneCare Connect with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare ~~or OneCare~~ Connect that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare ~~or OneCare~~ Connect. ~~OneCare or~~ 3. OneCare Connect's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare ~~or OneCare~~ Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. ~~OneCare or~~ OneCare Connect's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Provider Payment Dispute Resolution (PDR)	If a provider disagrees with the payment paid by CalOptima or Health Network, he or she has the right to dispute the payment. Non-Contracted Providers are required to accept as payment, in full, the amounts that the provider could collect if the Member were enrolled in original Medicare.

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Term	Definition
Prudent Layperson Standard	~~For the purposes of this policy, refers to the determination of needed emergency medical services, as described in Title 42, Code of Federal Regulations, Section 422.113(b)(1), by a prudent layperson with~~A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Remittance Advice (RA)	~~A Remittance Advice (RA) is a notice of payments and adjustments Medicare Contractors sends to providers, billers and suppliers after they process a claim. After Medicare processes a claim, CalOptima shall send to the Provider a form of Remittance Advice, which may include adjudication decisions for multiple claims in an itemized format. The RA explains reimbursement decisions, including the reason for payments and adjustments based on itemized claims processing decisions.~~ A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Reopening	A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
Waiver of Liability	The Waiver of Liability statement ensures the Non-Contracted Provider shall hold the Member harmless regardless of the outcome of the Appeal.

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For 20220505 BOD Review for Ratification

Policy:	MA.9009
Title:	**Non-Contracted Provider Payment Appeals**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2010
Revised Date:	04/01/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy defines the process by which CalOptima ensures that Non-Contracted Providers (NCP) have clear and reliable access to an Appeal process that meets the requirement of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima and Health Networks shall establish and maintain a process that addresses the receipt, handling, and disposition of an Appeal for NCPs in accordance with applicable statutes, regulations, contractual requirements, and the terms and conditions of this policy.

B. CalOptima and Health Networks shall provide all parties to an Appeal with reasonable opportunity to present evidence, or allegations, of fact, or law, related to the issue in dispute in writing. CalOptima shall take all evidence into account when making its decision.

C. The CalOptima Claims Administration Department and Health Networks shall process Provider Payment Dispute Resolutions (PDRs) involving payment disputes regarding payment being less than that paid by Medicare fee-for-service, within forty-five (45) business days after receipt of such PDR.

D. In the case of a PDR, CalOptima's Claims Administration Department and Health Networks shall inform the NCP in the notice of PDR decision of his or her right to file a complaint with CalOptima, in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

E. CalOptima and the Health Networks shall process all NCP claims payment disputes as Appeals, within sixty (60) calendar days of receipt of the Waiver of Liability (WOL) form. NCP claims payment disputes can constitute any organization determination that leads to a fully or partially adverse determination. Organization determinations include, but are not limited to the following situations:

1. A reopening, which leads to a fully or partially adverse determination;

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2. Diagnosis code/DRG payment denials: An NCP submits a claim to CalOptima. CalOptima initially approves the claim, which is considered a favorable organization determination (pursuant to Title 42 Code of Federal Regulations (CFR), section 422.566(b)). CalOptima later reopens and revises the favorable organization determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds;

3. Downcoding: CalOptima approves coverage for inpatient services from a NCP, which is considered a favorable organization determination (pursuant to Title 42, CFR section 422.566(b)). CalOptima later reopens and revises the favorable organization determination (e.g., retrospective review) and determines the Member should have received outpatient services; and

4. Bundling issues and disputed rate of payment: Pre- and post-pay bundling and global payment determinations. For example, denial of procedure codes – as mutually exclusive to another, or due to inclusion in a previously paid global surgical package.

5. Level of care or rate of payment denials: Payment of a reduced fee schedule amount for a course treatment. For example, a provider bills a procedure code for a visit, but CalOptima reimburses based on a lower level of care.

F. NCPs may file an Appeal with the CalOptima Grievance and Appeal Resolution Services (GARS) Department or the Health Network, within sixty (60) calendar days from the receipt of the Remittance Advice (RA) for all payment disputes, notwithstanding PDRs as described in Section II.D. of this Policy.

G. CalOptima and the Health Networks shall notify an NCP of the Appeal process:

1. In all RAs;

2. On the CalOptima Website at www.caloptima.org; and

3. Upon request by the NCP.

III. PROCEDURE

A. Submission of an Appeal request involving Claims payment dispute:

1. An NCP shall submit the initial payment dispute, in writing, within the required timeframe using the Provider Complaint Resolution Request or a letter and shall include:

i. The Member's name;

ii. Medicare Beneficiary Identifier (MBI) (formally known as Medicare Health Insurance Claim (HIC) number) or Client Index Number (CIN);

iii. The specific service(s) and/or items(s) for which the Appeal is being requested;

iv. The specific date(s) of the service;

v. Copy of the original claim or remittance notification showing the denial;

vi. The name and signature of the party or the representative of the party filing the request;

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vii. A Waiver of Liability Form; and

viii. Any additional information that supports the request, including, but not limited to, Medical Records.

2. CalOptima or a Health Network shall notify the Provider if any required information as stated in Section III.A.1. of this Policy is missing. If the information is not submitted within the required timeframe, CalOptima shall process the Appeal in accordance with Sections III.B., and III.C. of this Policy.

B. For a PDR handled by a Health Network or CalOptima Claims Administration Department:

1. For disputes for a payment less than that paid by Medicare fee-for-service, the NCP shall file the dispute with the payer as identified on the RA, either the Health Network or CalOptima Claims Administration Department.

a. Contact information for Health Networks is available on the CalOptima website at www.caloptima.org, or by contacting CalOptima's Health Network Relations Department at 714-246-8600.

b. Claims processed by CalOptima Claims Administration Department, mail to:

CalOptima Claims Department— Provider Dispute Unit
P.O. Box 57015
Irvine, CA 92619

C. CalOptima's Claims Administration Department and the Health Network shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request.

1. An NCP may file a complaint with CalOptima, in accordance with CalOptima Policy MA.9006: Provider Complaint Process:

a. If the NCP is not satisfied with the decision issued by the Health Network or CalOptima Claims Administration Department; or

b. A decision is not issued by the Health Network or CalOptima Claims Administration Department within the one hundred and eighty (180) calendar day time limit.

D. For an Appeal handled by CalOptima GARS or a Health Network, such Appeals are payment disputes from NCP Medicare providers, that are not PDRs:

1. File the request, in writing, within sixty (60) calendar days from the notice of denial with CalOptima GARS or the Health Network, based on the payer on the RA.

2. The NCP may request an extension to this timeframe for good cause by submitting a written request for such an extension that includes the reason the NCP cannot meet the timeframe, in accordance with Title 20 CFR, section 404.911.

3. Upon verification that the request meets criteria for processing as an Appeal, CalOptima GARS or the Health Network shall send an NCP an acknowledgement letter and a WOL form, if not already included with the Appeal request, after receipt of the Appeal request.

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4. If the NCP fails to submit a signed WOL form after three (3) attempts (written and verbal requests) by CalOptima GARS or the Health Network, the GARS Department or the Health Network shall notify the NCP that the request shall be dismissed due to lack of the WOL, no sooner than sixty (60) calendar days from the receipt of the request. The Notice of Dismissal of Appeal Request shall inform the NCP of the process and the right to request a review of the dismissal by the Independent Review Entity (IRE).

5. CalOptima GARS or the Health Network shall commence review of the Appeal upon receipt of the signed WOL form or letter of good cause, as applicable, and the review shall be completed within sixty (60) calendar days of that the receipt date.

6. Upon completion of review of the Appeal, GARS or the Health Network shall send a resolution letter to the NCP informing the NCP of the review decision within sixty (60) calendar days of receipt of the signed WOL form.

7. Failure of CalOptima GARS or the Health Network to provide the NCP with a decision within the sixty (60) calendar day period constitutes an adverse decision and GARS or the Health Network shall forward the Appeal to the IRE for review.

8. An Appeal decision which upholds in whole, or in part, the initial denial shall be forwarded to the IRE for review.

E. Appeal Review

1. CalOptima or the Health Network shall designate an individual other than the person involved in making the initial Organization Determination to review a request for Appeal.

   a. If the original denial is based on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service shall review the request for Appeal. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

   b. If the request for Appeal involves Emergency Services, CalOptima shall apply the Prudent Layperson Standard when reviewing the Appeal.

2. GARS staff or the Health Network shall present the Appeal request to the appropriate reviewer for decision.

3. CalOptima GARS or the Health Network shall document the decision made by the reviewer, the rationale for the decision, and include the name of the staff who reviewed the case in a Provider resolution letter.

4. If, upon the Appeal review, CalOptima or the Health Network completely reverses its adverse Organization Determination, GARS staff or the Health Network shall:

   a. Notify the Provider of the decision, in writing;

   b. Notify and request claim payment from CalOptima or the Health Network Claims Department;

   c. Verify that CalOptima or the Health Network made payment through the claims system and/or that a retro-authorization was issued;

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d. Ensure that CalOptima or the Health Network adjusts claims for payment within sixty (60) calendar days after the date of receipt of the request for Appeal;

e. Ensure that the NCP's case file includes documentation of payment and retro-authorization, if required; and

f. Note the Appeal as "closed" in the Appeals database.

5. If, upon Appeal review, CalOptima or the Health Network affirms, in whole, or in part, the adverse Organization Determination, CalOptima or the Health Network shall take the following actions:

a. Notify the NCP who requested the Appeal no later than sixty (60) calendar days after receipt of the signed WOL, including notice that CalOptima or the Health Network forwarded the Appeal to the IRE.

b. Forward a copy of the case file, and the Reconsideration Background Data Form and Case Narrative Form to the IRE, no later than sixty (60) calendar days of receipt of the signed WOL. The Health Network should notify CalOptima of submission to the IRE simultaneously with submission.

F. IRE Determination

1. The IRE shall make a decision on an Appeal in accordance with its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima or the Health Network within a specified timeframe using the IRE Request for Additional Information Form. Upon receipt of such request, CalOptima GARS staff or the Health Network shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Letter to IRE. The Health Network should notify CalOptima of any additional submissions to the IRE at the time of submission to the IRE.

3. If the IRE upholds CalOptima's or the Health Network's adverse Organization Determination, it shall notify CalOptima or the Health Network and the NCP of such decision, in writing. Upon receipt of such notice, GARS staff or the Health Network shall place the notice in the NCP's Appeal file. The Health Network should notify CalOptima of the final decision by the IRE within five (5) calendar days of notification.

4. If the IRE reverses or partially reverses CalOptima's or the Health Network's adverse Organization Determination, CalOptima GARS or the Health Network shall:

a. Coordinate with the CalOptima Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

b. Coordinate with the Health Network's Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than twenty (20) calendar days after notice from the IRE;

c. Notify the NCP of the IRE's decision and compliance with IRE decision;

d. Send a notification of compliance letter to the IRE; and

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e. Document all activities in the Appeal tracking system.

5. The Health Network shall notify CalOptima of the final decision by the IRE, with proof of effectuation within twenty (20) calendar days of notification.

G. Administrative Law Judge (ALJ) Hearing

1. An NCP that provided Covered Services to a Member has the right to a hearing before an ALJ if the projected value of the disputed service meets the threshold amount specified in the Medicare Managed Care Manual, as determined by Medicare regulations and the ALJ.

2. An NCP shall request an ALJ hearing by submitting such request:

a. In writing to CalOptima, or the IRE; and

b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The NCP may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the NCP cannot meet the timeframe in accordance with Title 20 CFR, section 40 4.911.

3. If CalOptima receives a request for an ALJ hearing from an NCP, CalOptima GARS staff shall forward the Provider request for ALJ hearing to the IRE. The IRE shall compile and forward the NCP's file to the ALJ.

4. If the Health Network receives a request for an ALJ hearing from an NCP, the Health Network shall forward the Provider request for ALJ hearing to the IRE with a Carbon Copy to CalOptima. The IRE shall compile and forward the NCP's file to the ALJ.

5. CalOptima or the Health Network shall not have the right to request an ALJ hearing but may remain a party to the hearing.

6. If the ALJ reverses CalOptima's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination unless it requests Medicare Appeals Council (MAC) review of the ALJ decision in accordance with Section III.H. of this Policy.

b. Request a MAC Hearing of the ALJ decision; and

c. Wait for the MAC's decision before it authorizes, or provides, the disputed service; and

d. Inform the IRE when it effectuates the decision.

H. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima, may request a MAC Hearing of the ALJ decision, or dismissal.

2. A party requesting a MAC Hearing shall submit such request:

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a. In writing, directly to the MAC; and

b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima receives an NCP's request for a MAC Hearing, it shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to the MAC.

4. If the Health Network receives an NCP's request for a MAC Hearing, it shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to CalOptima within five (5) days of receipt.

5. If CalOptima requests a MAC Hearing, it shall:

a. Submit a CalOptima Request for MAC Hearing and a complete case file to the MAC;

b. Concurrently notify the NCP of CalOptima's request by sending the Provider a copy of the request and all information submitted to the MAC; and

c. Notify the IRE of CalOptima's request.

5. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC shall notify all parties, in writing, of its decision to initiate such review.

6. If the MAC reverses CalOptima's or the Health Networks' initial adverse Organization Determination in whole, or in part, CalOptima or the Health Network shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and

b. Inform the IRE when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima may request a judicial review of an ALJ decision if:

a. The MAC denied the party's request for review; and

b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima, may request a judicial review of a MAC decision if:

a. The MAC denied the party's request for review; or

b. It is the final decision of CMS; and

c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain a judicial review unless the MAC has acted on the case.

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4. In order to obtain a judicial review, a party shall file a civil action in a district court of the United States in accordance with Section 205(g) of the Social Security Act.

5. CalOptima shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses CalOptima's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima or a Health Network shall:

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

J. Documentation of Data

1. CalOptima's GARS and Claims Administration Departments and Health Networks shall document all actions taken related to an Appeal request in its tracking system and/or hard copy including, but not limited to:

   a. Provider's name;

   b. Date received;

   c. Name of staff that received the complaint at CalOptima;

   d. Designated contact person;

   e. Description of the complaint;

   f. Date; and

   g. Disposition.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and the Centers for Medicaid and Medicare Services (CMS) for Cal MediConnect
C. CalOptima Policy MA.9006: Provider Complaint Process
D. Centers for Medicare & Medicaid Services Letter, Provider Payment Dispute Resolution for Non-Contracted Providers, January 4, 2010
E. "Part C Dismissals Procedure," Health Plan Management System (HPMS) Memorandum, Issued September 10, 2013
F. "Model Dismissal Notice," Health Plan Management System (HPMS) Memorandum, Issued October 30, 2013
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VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
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Medically Necessary/Medical Necessity	OneCare: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. 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.
Non-Contracted Provider (NCP)	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Organization Determination	Any determination made by OneCare Connect with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider other than OneCare Connect that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by OneCare Connect. 3. OneCare Connect's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by OneCare Connect; 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. OneCare Connect's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Provider Payment Dispute Resolution (PDR)	If a provider disagrees with the payment paid by CalOptima or Health Network, he or she has the right to dispute the payment. Non-Contracted Providers are required to accept as payment, in full, the amounts that the provider could collect if the Member were enrolled in original Medicare.
Prudent Layperson Standard	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Remittance Advice (RA)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Reopening	A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

For 20220505 BOD Review for Ratification

Term	Definition
Waiver of Liability	The Waiver of Liability statement ensures the Non-Contracted Provider shall hold the Member harmless regardless of the outcome of the Appeal.

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For 20220505 BOD Review for Ratification

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

16. Approve Modifications to CalOptima Policy HH.2005: Corrective Action Plan and Addition of CalOptima Policy AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process

Contact

Carmen Dobry, Executive Director, Compliance, (657) 235-6997

Recommended Actions

Pursuant to CalOptima's policy review process:

1. Approve modifications to Policy HH.2005: Corrective Action Plan; and
2. Approve new Policy AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process

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 the policies, which are reflected in the attached redline policies. The 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 HH.2005: Corrective Action Plan outlines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Plan (ICAP) or Corrective Action Plan (CAP) for areas of non – compliant performance, as identified by CalOptima's Office of Compliance. This policy was revised to further clarify CalOptima's CAP process.

Policy Section	Change
III.C	Updated procedures in instances of unacceptable resolution to an ICAP or CAP.
III.F	Added an example of a predetermined timeframe for monitoring activities.
III.H	Added self – disclosure reporting requirements for ICAPs and significant incidents of non – compliance.

Policy AA.1275: Policy AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process outlines CalOptima's process for the DHCS's File and Use submission. This policy was created to align with the DHCS's File and Use requirements issued to the managed care plans (MCPs) in October 2021 included as an attachment within the policy.

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Policy Section	Overview
II.A	Outlines the applicable Medi-Cal materials that CalOptima may submit through the File and Use submission process.
III.A – B	Outlines the process by which CalOptima departments shall submit File and Use Materials, including the signed attestation form.

Fiscal Impact

The recommended action to approve changes to HH.2005 and new policy AA.1275 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.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1_HH.2005_Corrective Action Plan
2. Attachment 2_AA.1275_Department of Health Care Services (DHCS) File and Use Process

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	~~Regulatory Affairs & Compliance~~Not Applicable
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP, or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

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III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of ICAP response or CAP response;

    e. Individual(s) responsible for implementation of the ICAP response or CAP response;

    f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

    g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or to the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an ICAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

    d. A revised response timeline of five (5) business days for a CAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

    f. ~~Possibility of escalating~~Escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

    g. ~~Possibility of referral~~Notice to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP

response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

a. An acknowledgement of acceptance;

b. A description of follow up actions which shall include, but is not limited to:

i. Submission of finalized documentation; and/or

ii. Focused Audit, as described in Section III.E. of this Policy; and/or

iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

a. An acknowledgement of closure;

b. The effective date of closure; and

c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal ~~department's~~departments or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee~~.~~

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance ~~issues an~~ makes a determination to self-disclose the ICAP ~~request~~or significant incident of noncompliance with respect to the CalOptima Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager ~~for Medi-Cal within three (3) business days of issuance.~~and/or CMS Account Manager.

   a) The Office of Compliance will submit the Self-Disclosure report to the Compliance Officer for review and sign off.

   b) Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in accordance with CalOptima Policy MA.9124: CMS Self-Disclosure, and three (3) business days for Medi-Cal ICAPs.

   ~~a)~~c) CalOptima shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

~~3.~~4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy MA.9124: CMS Self-Disclosure
~~G.~~H. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
I. Medicare Managed Care Manual, Chapter 21
J. Medicare Prescription Drug Benefit Manual, Chapter 9
K. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
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	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee (AOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors, and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	Means 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.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services, or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations, or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations, or staffing.

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
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 a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

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Policy:	HH.2005Δ
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima's Office of Compliance.

II. POLICY

A. CalOptima's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal CalOptima departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements related to CalOptima programs.

B. CalOptima's Office of Compliance may require that an internal department or FDR develop an ICAP, or CAP response based on the identified area(s) of non-compliance.

C. CalOptima's Office of Compliance shall require CalOptima internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements, which CalOptima or its regulators have identified as non-compliant, within time frames established by CalOptima's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima policy, or other requirements to CalOptima's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Policy HH.2002Δ: Sanctions.

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III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

    a. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

    b. CalOptima's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima's Office of Compliance shall coordinate its efforts with CalOptima's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

    a. If the finding requires an ICAP request, as determined by CalOptima's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

    b. The internal department or FDR shall provide a written response within three (3) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within fourteen (14) calendar days. CalOptima's Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of ICAP response or CAP response;

    e. Individual(s) responsible for implementation of the ICAP response or CAP response;

    f. An attestation by the internal department or FDR conveying a plan to remedy its identified deficiencies; and

    g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima's Office of Compliance shall issue a written notice to the internal department or to the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an ICAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

    d. A revised response timeline of five (5) business days for a CAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima's Compliance Officer or Designee.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Policy HH.2002Δ: Sanctions;

    f. Escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

    g. Notice to the Audit & Oversight Committee and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima's Compliance Officer or Designee, CalOptima's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima's Office of Compliance may conduct Monitoring of the internal departments or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima's Office of Compliance shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima's Office of Compliance.

3. CalOptima's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Compliance Officer, or Designee

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima's Office of Compliance shall report the status of all CAP/ICAP requests to the Audit & Oversight Committee and the Compliance Committee.

3. In the event that CalOptima's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the CalOptima Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima's DHCS Contract Manager and/or CMS Account Manager.

   a) The Office of Compliance will submit the Self-Disclosure report to the Compliance Officer for review and sign off.

   b) Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in accordance with CalOptima Policy MA.9124: CMS Self-Disclosure, and three (3) business days for Medi-Cal ICAPs.

   c) CalOptima shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

4. If CalOptima's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the Audit & Oversight Committee and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy HH.2002Δ: Sanctions
G. CalOptima Policy MA.9124: CMS Self-Disclosure
H. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
I. Medicare Managed Care Manual, Chapter 21
J. Medicare Prescription Drug Benefit Manual, Chapter 9
K. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
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	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	08/01/2008	MA.9104	Corrective Action Plan	OneCare
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	08/02/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws, and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Audit & Oversight Committee (AOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
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.
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.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors, and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	Means 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.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services, or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations, or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations, or staffing.

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
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 a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.

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Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

Responsible Party (CalOptima or Delegated Entity)		**Case #**	
		CAP Type: Immediate (ICAP) or Standard (CAP)	
Department (if applicable)		**Date CAP Sent by CalOptima**	
Date of Incident		**Date CAP Due to CalOptima**	
Investigator Name		**CAP Submitted By**	
Line of Business		**Date CAP Submitted**	

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CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status
1	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (eg P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training ☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			

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Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

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		2) What step(s) have been taken to resolve *each* root cause of the deficiency?			
		3) What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?			
		4) How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

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CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status
2	**Background:** **Applicable References and Standards:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (eg P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

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	Findings and Actions:	☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			
		2) What step(s) have been taken to resolve *each* root cause of the deficiency?			
		3) What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?			
		4) How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

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Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima's Office of Compliance is responsible for completing all cells in blue.

CAP Attestation:

I, _____ [NAME/TITLE] hereby have the authority to attest that the CAP(s), and subsequent remediation, as stated above, accurately reflect _____ [BUSINESS OWNER/DELEGATE] plan to remediate and execute the above referenced area(s) of non-compliance.

Generated by: (Responsible Party)	Name, Title	Signature	Date
Approved by: (CalOptima Office of Compliance)	Name, Title	Signature	Date

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Policy:	AA.1275
Title:	**Department of Health Care Services (DHCS) File and Use Submission Process**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy outlines CalOptima's process for Department of Health Care Services (DHCS) File and Use materials submissions.

II. POLICY

A. CalOptima may submit the following applicable Medi-Cal materials to DHCS through the File and Use submission process:

1. Policies not required by DHCS, by contract or an All Plan Letter (APL) requirement.

2. Policies (including policy attachments), with minor revisions required by DHCS that do not impact CalOptima's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance. Examples of these minor revisions include but may not be limited to:

   a. An adjustment of internal timelines or functions between CalOptima departments that do not impact DHCS contractual requirements;

   b. Rearrangement of policy and procedure language that does not alter policy intent, or impact DHCS contractual requirements;

   c. Revisions to grammar or punctuation, or updates to glossary terms, or references;

   d. Updates to phone numbers or addresses; and

   e. Language clarifications that do not substantively change the Policy, such as revising 'working' to 'business' days.

3. Redline versions of minor changes to deliverables/submissions that were already reviewed and approved by the DHCS within the last six (6) months and do not impact CalOptima's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance. Examples of these minor revisions may include but are not limited to:

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a. An adjustment of internal timelines or functions between CalOptima departments that do not impact DHCS contractual requirements;

b. Updates to phone numbers or addresses; and

c. Grammatical or punctuation updates.

d. Page reference updates to previously approved Member Material Approval (MMA) documents.

4. Consent forms (i.e., authorized representative forms, minor consent forms, etc.)

B. By contract, DHCS reserves the right to review, modify, stop, approve, deny CalOptima's right to use, or require CalOptima to edit, submitted materials at any time.

III. PROCEDURE

A. If materials have met the requirements for DHCS' File and Use flexibilities in accordance with Section II.A. of this Policy, Departments shall submit File and Use materials as follows:

1. Policies

a. Policy Owners shall submit the following to the Regulatory Affairs & Compliance Policies and Procedures (RAC P&P) team:

i. The DHCS Medi-Cal Managed Care Plan File and Use Attestation Form completed in accordance with Section III.B.;

ii. Revised policy, attachment(s) if applicable, and the Policy Intake Form [PIF] - Policy Revisions; and

iii. Any additionally required documents in accordance with the CalOptima Policy Owner Manual.

b. Upon receipt of the completed submission, the RAC P&P team will verify readiness, and coordinate with RAC Medi-Cal for File and Use submission to DHCS.

2. Deliverables/Submissions

a. The department responsible for the specific deliverables/submissions shall submit the following to the Regulatory Affairs & Compliance Medi-Cal (RAC Medi-Cal) team:

i. The DHCS Medi-Cal Managed Care Plan File and Use Attestation Form completed in accordance with Section III.B;

ii. Redline versions of all minor changes to deliverables/submissions from the responsible department.

3. Upon review of materials listed in Sections III.A.1 and III.A.2, the RAC Medi-Cal and RAC P&P teams reserve the right to reclassify materials if deemed inappropriate for submission as a File and Use material.

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B. Attestation Form

1. The completed Medi-Cal Managed Care Plan File and Use Attestation Form is required to accompany each submission and must be completed when CalOptima intends to use or implement any CalOptima materials prior to DHCS review and approval (File and Use).

2. The Attestation Form must be signed by CalOptima's Chief Executive Officer (CEO), Chief Operating Officer (COO), or Compliance Officer (CO), or an individual who reports directly to the CEO, COO, or CO with delegated authority to sign for the CEO, COO, or CO, so that the CEO, COO, or CO is ultimately responsible for the Attestation Form.

3. The Policy Owner or department responsible for the specific deliverables/submissions is responsible for obtaining the appropriate signature according to department hierarchy and as listed in Section III.B.2.

IV. ATTACHMENT(S)

A. DHCS File and Use Attestation Form
B. 2022 Policy Intake Form [PIF] - Policy Revisions

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy Owner Manual
C. Department of Health Care Services (DHCS), [Medi-Cal]: File and Use Flexibilities Memo

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	AA.1275	Department of Health Care Services (DHCS) File and Use Submission Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
File and Use	A submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined.
Policy	A formal document that communicates broad principles of operation and standards on a particular subject to guide the actions and decision-making of individuals. Desktop policies and procedures are not included.
Policy Owner	The Director-level staff member who has lead responsibility for the policy and procedure, as part of his/her job duties.

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Medi-Cal Managed Care Plan
File and Use Attestation Form

This File and Use Attestation Form (Attestation Form) is required to be completed when _____ (Contractor) intends to use or implement any Contractor materials prior to DHCS review and approval (File and Use).

This Attestation Form must be completed by the Chief Executive officer (CEO), Chief Operating Officer (COO), or Compliance Officer (CO), or or an individual who reports directly to the CEO, COO, or CO with delegated authority to sign for the CEO, COO, or CO, so that the CEO, COO, or CO is ultimately responsible for the Attestation Form.Contractor must submit this Attestation Form whenever Contractor submits a Contractor material for File and Use, and Contractor must attach the Contractor material to this Attestation Form.

The following types of Contractor materials may be submitted for File and Use:

- P&Ps not required by DHCS (i.e., P&Ps that are not a contract or an APL requirement)
- Minor updates to P&Ps required by DHCS (i.e. minor updates to P&Ps that do not impact Contractor's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance)
- Minor changes to deliverables/submissions that were already reviewed and approved by DHCS within the last six months. Contractor must submit a redline version of all changes. In addition, the changes must not impact Contractor's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance.
- Consent forms (i.e. authorized representative forms, minor consent forms, etc.)
- In-person marketing events, not including Annual Marketing Plans. All Annual Marketing Plans must be submitted to DHCS for review and approval prior to use.

By signing this Attestation Form, Contractor represents, warrants, and attests that the attached Contractor materials comply with all federal and state laws, regulations, and guidance, and contractual requirements as set forth in the Medi-Cal managed care contract (Contract) between the Department of Health Care Services (DHCS) and Contractor. Contractor also certifies that the attached Contractor materials are

complete,accurate, and truthful based upon Contractor's best information, knowledge and belief after making a diligent and thorough search and review of all records and information within Contractor's control.

Contractor retains full legal responsibility for the use of the attached Contractor materials and agrees to indemnify and hold harmless the State of California, DHCS, and its officers, agents, employees, control agencies, and other state agencies for any and all claims, losses, injuries, damages, attorneys' fees and costs, and judgments resulting from the use of the attached Contractor materials. Contractor also agrees and acknowledges to abide by all other indemnification provisions contained in its Contract with DHCS.

Contractor acknowledges DHCS retains all of its rights under the Contract, including but not limited to, its right to review, modify, stop, approve, or deny the Contractor's right to use the attached Contractor materials. Alternatively, Contractor acknowledges DHCS' right to require Contractor to edit the Contractor materials at any time.

Attestation

I hereby attest on behalf of _____ (Contractor) that it has complied with and will continue to comply with all requirements set forth above.

Signature _____ Date _____

_____
(Name of CEO, COO, or Compliance Officer)

_____
(Printed Name of Contractor)

_____
(City, State)

The following shall have the same legal force and effect as an original of the signed Attestation Form: a facsimile, photocopy, imaged or other electronic version.

When completed, please send the signed Attestation Form to your assigned DHCS Contract Manager.

Policy Intake Form (PIF) – Policy Revisions

Please complete **ALL THE FIELDS** below and submit this form to Regulatory Affairs & Compliance – Policies & Procedures (RAC-P&P) along with the new, revised, or retired policy, and **ALL** applicable supporting documents (e.g., COBARS and attachments).

For questions, please contact: RACPolicies@caloptima.org

I.	**Today's Date:**		
II.	**Policy Number:**		
III.	**Policy Title:**		
		Was the policy title revised? ☐ Yes ☐ No	If yes, please provide the new title:
IV.	**Responsible Department:**		
		Is this policy being transferred to another department? ☐ Yes ☐ No	If yes, list department confirming acceptance of transfer:
V.	**Program(s) this Policy will apply to:**	☐ Medi-Cal ☐ OneCare	☐ OneCare Connect ☐ PACE ☐ Administrative – Internal ☐ Administrative – External
VI.	**Preferred Policy Review Committee (PRC) Month:**		
VII.	**Policy Presenter for PRC:**		
VIII.	**Reason for Policy Action:**	☐ New/Revised Regulatory Guidance and/or Contract(s)	[Please include evidence/sourced documentation]
		☐ Retirement	[Requires crosswalk document if content is transferring to another policy]
		☐ Operational change(s)	[Please include evidence/sourced documentation]
		☐ Audit Remediation	[Please include evidence/sourced documentation]
		☐ CalOptima Board/Committee Request	[Please include evidence/sourced documentation]
		☐ New Policy	[Please include evidence/sourced documentation]
		☐ Other	[Please include evidence/sourced documentation]

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Policy Intake Form (PIF) – Policy Revisions

IX. **Summary of Main Edits**: *[Additional lines available at the end of the form]*	***Page and Section***	***Revision***	***Reason for Revision*** *[Be as specific as possible when citing contract provision(s), regulations, etc.]*
X. Additional Department Impact:	☐ Yes [List Dept/Reviewer(s)]: 1. 2.		☐ No

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Policy Intake Form (PIF) – Policy Revisions

XI. Attachments: ***Note:*** *PO is responsible to ensure attachments posted elsewhere are updated upon policy completion.*	[If document is managed by another department, please ensure attachments are current and in use.] Note: Please fill out the boxes below with the applicable Attachment information. Attachment A: Click or tap here to enter text. ☐ No Revisions Made ☐ Revisions Made [Show changes in Section IX. Summary of Main Edits] ☐ Replaced with Most Recent Attachment [For DHCS/CMS forms only] ☐ New Attachment ☐ Retiring Attachment [Action specific to this policy only] Attachment B: Click or tap here to enter text. ☐ No Revisions Made ☐ Revisions Made [Show changes in Section IX. Summary of Main Edits] ☐ Replaced with Most Recent Attachment [For DHCS/CMS forms only] ☐ New Attachment ☐ Retiring Attachment [Action specific to this policy only] Attachment C: Click or tap here to enter text. ☐ No Revisions Made ☐ Revisions Made [Show changes in Section IX. Summary of Main Edits] ☐ Replaced with Most Recent Attachment [For DHCS/CMS forms only] ☐ New Attachment ☐ Retiring Attachment [Action specific to this policy only] Attachment D: Click or tap here to enter text. ☐ No Revisions Made ☐ Revisions Made [Show changes in Section IX. Summary of Main Edits] ☐ Replaced with Most Recent Attachment [For DHCS/CMS forms only] ☐ New Attachment ☐ Retiring Attachment [Action specific to this policy only] Attachment E: Click or tap here to enter text. ☐ No Revisions Made ☐ Revisions Made [Show changes in Section IX. Summary of Main Edits] ☐ Replaced with Most Recent Attachment [For DHCS/CMS forms only] ☐ New Attachment ☐ Retiring Attachment [Action specific to this policy only] Attachment F: Click or tap here to enter text. ☐ No Revisions Made ☐ Revisions Made [Show changes in Section IX. Summary of Main Edits] ☐ Replaced with Most Recent Attachment [For DHCS/CMS forms only] ☐ New Attachment ☐ Retiring Attachment [Action specific to this policy only] ☐ No Attachments

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Policy Intake Form (PIF) – Policy Revisions

XII. Additional Policy Review:	☐ Yes ☐ No	
	☐ Legal Affairs Is there a specific legal question or issue to be addressed by Legal Affairs? ☐ Yes ☐ No Is your department making any legal decisions as incorporated in policy revisions? ☐ Yes ☐ No *If unsure, please answer the questions below to assist in making a determination:* Does this policy contain language pertaining to: ▪ Compliance ☐ Yes ☐ No ▪ Grievance & Appeals ☐ Yes ☐ No ▪ Human Resources ☐ Yes ☐ No ▪ Credentialing and/or Recredentialing ☐ Yes ☐ No ▪ Finance ☐ Yes ☐ No ▪ Member rights ☐ Yes ☐ No ▪ Provider rights ☐ Yes ☐ No ▪ New CalOptima program/initiative ☐ Yes ☐ No ☐ Board of Directors [*Preferred meeting date*]: Click or tap here to enter text. ☐ Board of Directors Subcommittee [*Preferred meeting date*]: Click or tap here to enter text. ☐ CalOptima Committee(s) [*Preferred meeting date*]: Click or tap here to enter text. [Please note: These are only target meeting dates for planning purposes, a Policy Owner must wait to schedule policy meeting dates, after PRC approves the policy.]	
XIII. DHCS File and Use	☐ Yes ☐ No Reasoning for Determining DHCS File and Use: Click or tap here to enter text. [Please review CalOptima Policy AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process, to determine whether the File and Use process is appropriate for this Policy. If this process is confirmed, please fill out and submit the File and Use Attestation Form along with this PIF, Policy, applicable attachments, and supporting documentation].	
XIV. Point(s) of Contact:	Primary:	
	Secondary:	

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XV. Attestation:	[Only Manager or Director-level staff can Attest] I attest that the information contained in this document is true and accurate to the best of my knowledge and that department management (including Executive Director/Chief) has been informed of the operational changes and revisions made to this policy. I further understand that any misrepresentation of information on this document may cause a delay in processing or rejection of the policy for processing. ☐ I agree Name:
XVI. Notes/Comments:	

Additional lines [if needed] for section IX. Summary of Main Edits:		
Page and Section	***Revision***	***Reason for Revision*** *[Be as specific as possible when citing contract provision(s), regulations, etc.]*

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Policy Intake Form (PIF) – Policy Revisions

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

17. Approval of Modifications for CalOptima Claims Administration Policies FF.1003, FF.2004, FF.2011, FF.2012 and MA.3101

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions

Approve modifications to the following Claims Administration policies and procedures:

1. Policy FF.1003 Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group;
2. Policy FF.2004 Financial Responsibility for Newborn Coverage;
3. Policy FF.2011 Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services;
4. Policy FF.2012 Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services; and
5. Policy MA.3101 Claims Processing.

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 the rationale for the 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 (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

1. **Policy FF.1003 Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group** describes payment methods for a Provider or Practitioner that provides Covered Services to CalOptima Member or Shared Risk Group Member, where CalOptima is financially responsible. This policy was updated to align with the requirements of All Plan Letter (APL) 21-008 Tribally Federally Qualified Health Center (FQHC) Providers.

2. **Policy FF.2004 Financial Responsibility for Newborn Coverage** describes Claim Administration Department responsibilities that ensure coverage of Neonatal Intensive Care Unit

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(NICU) / Pediatric Intensive Care Unit (PICU) eligible members through their second month of life when a newborn's mother is Medi-Cal eligible and enrolled in CalOptima. This policy outlines the financial responsibility for covered services provided to a newborn. The policy was updated to align with the requirements of APL 21-005 California Children's Services (CCS) Whole Child Model Program (WCM).

3. **Policy FF.2011 Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services** describes the process for Proposition 56 physician payments and Ground Emergency Medical Transport (GEMT) for the delegated Health Networks. This policy was updated to align with the requirements of Department of Health Care Services (DHCS) State Plan Amendment (SPA) 21-0017, which allows the continuation of the add-on to the fee-for-service (FFS) fee schedule rates for eligible GEMT services provided to Medi-Cal patients through June 30, 2022. The policy was also updated to align with requirements from APL 21-008 requiring Managed Care Plans (MCP) to make payments to Tribal FQHC providers for eligible services provided on or after the implementation date of July 1, 2021.

4. **Policy FF.2012 Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services** describes the process for Proposition 56 physician payments and GEMT for the Shared Risk Group. This policy was updated to align with the requirement of DHCS SPA 21-0017, which allows the continuation of the add-on to the FFS fee schedule rates for eligible GEMT services provided to Medi-Cal patients through June 30, 2022. The policy was also updated to align with requirements from APL 21-008 requiring MCP to make payments to Tribal FQHC providers for eligible services provided on or after the implementation date.

5. **Policy MA.3101 Claims Processing** describes the CalOptima claims processing department's responsibilities and ensures the timely and accurate submission and adjudication of claims for covered services. This policy was updated to include the non-contracted provider's access to the Medicare administrative appeal process.

Fiscal Impact

The recommended action to approve changes to CalOptima Policies FF.1003, FF.2004, FF.2011, FF.2012, and MA.3101 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. Policy FF.1003 Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group (Red Lined and Clean)
2. Policy FF.2004 Financial Responsibility for Newborn Coverage (Red Lined and Clean)
3. Policy FF.2011 Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services (Red Lined and Clean)
4. Policy FF.2012 Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services (Red Lined and Clean)
5. Policy MA.3101 Claims Processing (Red Lined and Clean)
6. DHCS All Plan Letter 21-005 California Children's Services While Child Model Program
7. DHCS All Plan Letter 21-008 Tribally Federally Qualified Health Center Providers
8. SPA 21-0017 One-year reimbursement rate add-on for eligible ground emergency medical transports with dates of service between July 1, 2021, and June 30, 2022

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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Policy:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 2022050 BOD Review Only

I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

~~A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:~~

~~1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.~~

~~2. Non-Contracted Hospital: CalOptima's reimbursement to a non-contracted hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's Prior Authorization policies, is as follows:~~

~~a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.~~

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b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Out of State Hospitals: For dates of service on or after July 1, 2013Except as provided in Section III.A.2.d.i. of this Policy, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code, for dates of service on or after July 1, 2013.

i. Border Hospitals: CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency/Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

4. If a Member changes Health Networks, including CalOptima Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this policyPolicy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member as follows:

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~~Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.~~

~~1. Non-contracted Practitioner: CalOptima's reimbursement to a non-contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:~~

~~a. Emergency Services: CalOptima shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.~~

~~b. Non-Emergency Services: CalOptima shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:~~

~~i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.~~

~~ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program-paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.~~

~~iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.~~

~~iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.~~

~~v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.~~

~~vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.~~

~~vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.~~

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viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse a provider, including a non-contracted provider, for a (12) month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a Member's request by a qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

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a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

a. The American Indian Health Service Program provider must be identified by DHCS;

b. Service must be a Covered Service included in CalOptima's contract with DHCS;

c. Except as provided in Section II.E.5., and as set forth in California Medicaid State Plan Supplement 6. Attachment 4.19-BIII.E.5. of this Policy, only one rate payment per day, per category, shall be allowed within the following three (3) categories. as set forth in the California Medicaid State Plan Supplement 6. Attachment 4.19-B. This allows for a maximum of three (3) payments per day, one (1) from each category:

i. Medical health visit;

ii. Mental health visit;

iii. Ambulatory visit.

5. Tribal FQHC: Effective January 1, 2021, CalOptima shall reimburse a Tribal FQHC Provider, including an Indian Health Service providerCare Provider enrolled as an Indian Health Services Memorandum of Agreement (IHS-MOA) clinic that elected to participate in Medi-Cal as a Tribal FQHC providerProvider in accordance with the Alternate Payment Methodology (APM)), which is set at the All-Inclusive Rate (AIR). Once enrolled with DHCS, the DHCS will add the new Trial FQHC Provider and the following reimbursement requirements:

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a. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent (80%) of the Medicare FQHC prospective payment system rate.

b. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."

c. CalOptima shall ensure that the following criteria are met for receipt of payments:

i. The Tribal FQHC provider must be identified by DHCS;

ii. Service must be a Covered Service included in CalOptima's contract with DHCS;

iii. As set forth in DHCS All Plan Letter 21-008: Tribal Federally Qualified Health Center Providers and California State Plan Amendment to Attachment 4.19-B, CA-20-0044, a Tribal FQHC providerProvider shall be reimbursed at the applicable rate for up to three (3) visits per day, per Member in any combination of different visits in the following visit categories:

1) Medical health visit;

2) Mental health visit; and

3) Ambulatory visit.

. A Tribal FQHC Provider may expand its service locations outside of the clinic facility when services are provided by clinic providers or provider contracting with the Tribal FQHC Provider.

6. Certain Covered Services shall be reimbursed outside of the OMB or APM rate, including Non-Medical Transportation, Non-Emergency Medical Transportation, and pharmacy services.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted Ancillary Service Provider based on the terms and conditions of the contract between such contracted Ancillary Service Provider and CalOptima.

2. CalOptima shall reimburse a non-contracted Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments

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for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

- Financial Responsibility for Medically Necessary Post-Stabilization Services: Subject to compliance with all applicable Claims policies and Utilization Management (UM) policies, including but not limited to, authorization, medical records, coding and billing requirements, CalOptima's financial responsibility for Medically Necessary Post-Stabilization Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group are as follows:

  - Contracted Provider: CalOptima is financially responsible for Medically Necessary Post-Stabilization Services rendered by a contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group in accordance with their contract.

  - Non-Contracted Provider:

    - CalOptima is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group that are:

      - Pre-approved by CalOptima or the Shared Risk Group, as applicable.

      - Not pre-approved by CalOptima or the Shared Risk Group, as applicable, but administered to maintain the Member's stabilized condition within one (1) hour of a request to CalOptima or the Shared Risk Group for Prior Authorization of further Post-Stabilization Services.

    - CalOptima is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group that are not pre-approved by CalOptima or the Shared Risk Group, as applicable, but administered to maintain, improve, or resolve the Member's stabilized condition if:

      - CalOptima or the Shared Risk Group, as applicable, does not respond within thirty (30) minutes after receipt of a written request for Prior Authorization for Medically Necessary Post-Stabilization Services, that fully complies with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable;

      - CalOptima or the Shared Risk Group, as applicable, cannot be contacted; or

      - A representative of CalOptima or the Shared Risk Group, as applicable, and the treating physician cannot reach an agreement concerning the Member's care, and CalOptima or the Shared Risk Group's plan physician is not available for consultation. In this situation, CalOptima or the Shared Risk Group must give the treating physician the opportunity to consult with CalOptima or the Shared Risk Group's plan physician, as applicable, and the treating physician may continue with care of the Member until such plan physician is reached or one (1) of the criteria in 42 C.F.R. § 422.113(c)(3) is met, as set forth in Section III.H.2.d of this Policy.

    - Notwithstanding Section III.H.2.b.i. of this Policy, CalOptima has the authority to disapprove payment for the delivery of Post-Stabilization Services or the continuation of the

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~~delivery of Post-Stabilization Services, if CalOptima or the Shared Risk Group notifies the non-contracted Provider of the denial of a request prior to the commencement of the delivery or during the delivery of Post-Stabilization Services in accordance with the requirements of CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable. In that event and subject to Section III.H.3.c.i. of this Policy, CalOptima shall not be obligated to pay for the continuation of Post-Stabilization Services from and after the time CalOptima or the Shared Risk Group, as applicable, provides such notice.~~

- ~~CalOptima shall pay for all Medically Necessary health care services provided to a Member which are necessary to maintain the Member's stabilized condition up to the time that CalOptima or the Shared Risk Group, as applicable, effectuates the Member's transfer or the Member is discharged.~~

~~CalOptima's financial responsibility for Medically Necessary Post-Stabilization Services not pre-approved ends when:~~

- ~~CalOptima or the Shared Risk Group's plan physician, as applicable, with privileges at the treating hospital assumes responsibility for the Member's care;~~
- ~~CalOptima or the Shared Risk Group's plan physician, as applicable, assumes responsibility for the Member's care through transfer;~~
- ~~A representative of CalOptima or the Shared Risk Group, as applicable, and the treating physician reach an agreement concerning the Member's care; or~~
- ~~The Member is discharged.~~

~~Denial and Transfer: In the event that CalOptima or a Shared Risk Group denies a Prior Authorization request for Post-Stabilization Services from a non-contracted Provider, and transfers the Member to a contracted Provider, payment shall be made for Medically Necessary health care services furnished to the Member to maintain his or her stabilized condition up to the time that the Member's transfer is effectuated.~~

~~No Prior Authorization Request. If a non-contracted Provider does not seek a Prior Authorization request for Post-Stabilization Services from CalOptima or the Shared Risk Group, then CalOptima is only financially responsible for Emergency Services rendered, and not for Post-Stabilization Services.~~

~~3. The CalOptima Claims Department shall contact the CalOptima Utilization Management Department for clarification of any questions regarding an authorization of Post-Stabilization Services using the internal routing process.~~

A. Non-contracted hospitals, non-contracted Practitioners, and non-contracted Ancillary Service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

B. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

C. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative

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Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima's reimbursement to a non-contracted hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's Prior Authorization policies, is as follows:

a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

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d. Out of State Hospitals: Except as provided in Section III.A.2.d.i. of this Policy, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code, for dates of service on or after July 1, 2013.

i. Border Hospitals: CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

4. If a Member changes Health Networks, including CalOptima Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this Policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-contracted Practitioner: CalOptima's reimbursement to a non-contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

a. Emergency Services: CalOptima shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. Non-Emergency Services: CalOptima shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program-paneled Provider, and who is

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recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse a provider, including a non-contracted provider, for a (12)-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a Member's request by a qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

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2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

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4. CalOptima shall ensure that the following criteria are met for receipt of payments:

   a. The American Indian Health Service Program provider must be identified by DHCS;

   b. Service must be a Covered Service included in CalOptima's contract with DHCS;

   c. Except as provided in Section III.E.5. of this Policy, only one rate payment per day, per category, shall be allowed within the following three (3) categories as set forth in the California Medicaid State Plan Supplement 6. Attachment 4.19-B. This allows for a maximum of three (3) payments per day, one (1) from each category:

      i. Medical health visit;

      ii. Mental health visit;

      iii. Ambulatory visit.

5. Tribal FQHC: Effective January 1, 2021, CalOptima shall reimburse a Tribal FQHC Provider, including an Indian Health Care Provider enrolled as an Indian Health Services Memorandum of Agreement (IHS-MOA) clinic that elected to participate in Medi-Cal as a Tribal FQHC Provider in accordance with the Alternate Payment Methodology (APM), which is set at the All-Inclusive Rate (AIR). Once enrolled with DHCS, the DHCS will add the new Trial FQHC Provider and the following reimbursement requirements:

   a. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent (80%) of the Medicare FQHC prospective payment system rate.

   b. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."

   c. CalOptima shall ensure that the following criteria are met for receipt of payments:

      i. The Tribal FQHC provider must be identified by DHCS;

      ii. Service must be a Covered Service included in CalOptima's contract with DHCS;

      iii. As set forth in DHCS All Plan Letter 21-008: Tribal Federally Qualified Health Center Providers and California State Plan Amendment to Attachment 4.19-B, CA-20-0044, a Tribal FQHC Provider shall be reimbursed at the applicable rate for up to three (3) visits per day, per Member in any combination of different visits in the following visit categories:

         1) Medical health visit;

         2) Mental health visit; and

         3) Ambulatory visit.

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d. . A Tribal FQHC Provider may expand its service locations outside of the clinic facility when services are provided by clinic providers or provider contracting with the Tribal FQHC Provider.

6. Certain Covered Services shall be reimbursed outside of the OMB or APM rate, including Non-Medical Transportation, Non-Emergency Medical Transportation, and pharmacy services.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted Ancillary Service Provider based on the terms and conditions of the contract between such contracted Ancillary Service Provider and CalOptima.

2. CalOptima shall reimburse a non-contracted Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

H. Financial Responsibility for Medically Necessary Post-Stabilization Services: Subject to compliance with all applicable Claims policies and Utilization Management (UM) policies, including but not limited to, authorization, medical records, coding and billing requirements, CalOptima's financial responsibility for Medically Necessary Post-Stabilization Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group are as follows:

1. Contracted Provider: CalOptima is financially responsible for Medically Necessary Post-Stabilization Services rendered by a contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group in accordance with their contract.

2. Non-Contracted Provider:

a. CalOptima is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group that are:

i. Pre-approved by CalOptima or the Shared Risk Group, as applicable.

ii. Not pre-approved by CalOptima or the Shared Risk Group, as applicable, but administered to maintain the Member's stabilized condition within one (1) hour of a request to CalOptima or the Shared Risk Group for Prior Authorization of further Post-Stabilization Services.

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b. CalOptima is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group that are not pre-approved by CalOptima or the Shared Risk Group, as applicable, but administered to maintain, improve, or resolve the Member's stabilized condition if:

i. CalOptima or the Shared Risk Group, as applicable, does not respond within thirty (30) minutes after receipt of a written request for Prior Authorization for Medically Necessary Post-Stabilization Services, that fully complies with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable;

ii. CalOptima or the Shared Risk Group, as applicable, cannot be contacted; or

iii. A representative of CalOptima or the Shared Risk Group, as applicable, and the treating physician cannot reach an agreement concerning the Member's care, and CalOptima or the Shared Risk Group's plan physician is not available for consultation. In this situation, CalOptima or the Shared Risk Group must give the treating physician the opportunity to consult with CalOptima or the Shared Risk Group's plan physician, as applicable, and the treating physician may continue with care of the Member until such plan physician is reached or one (1) of the criteria in 42 C.F.R. § 422.113(c)(3) is met, as set forth in Section III.H.2.d of this Policy.

c. Notwithstanding Section III.H.2.b.i. of this Policy, CalOptima has the authority to disapprove payment for the delivery of Post-Stabilization Services or the continuation of the delivery of Post-Stabilization Services, if CalOptima or the Shared Risk Group notifies the non-contacted Provider of the denial of a request prior to the commencement of the delivery or during the delivery of Post-Stabilization Services in accordance with the requirements of CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable. In that event and subject to Section III.H.3.c.i. of this Policy, CalOptima shall not be obligated to pay for the continuation of Post-Stabilization Services from and after the time CalOptima or the Shared Risk Group, as applicable, provides such notice.

i. CalOptima shall pay for all Medically Necessary health care services provided to a Member which are necessary to maintain the Member's stabilized condition up to the time that CalOptima or the Shared Risk Group, as applicable, effectuates the Member's transfer or the Member is discharged.

d. CalOptima's financial responsibility for Medically Necessary Post-Stabilization Services not pre-approved ends when:

i. CalOptima or the Shared Risk Group's plan physician, as applicable, with privileges at the treating hospital assumes responsibility for the Member's care;

ii. CalOptima or the Shared Risk Group's plan physician, as applicable, assumes responsibility for the Member's care through transfer;

iii. A representative of CalOptima or the Shared Risk Group, as applicable, and the treating physician reach an agreement concerning the Member's care; or

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iv. The Member is discharged.

e. Denial and Transfer: In the event that CalOptima or a Shared Risk Group denies a Prior Authorization request for Post-Stabilization Services from a non-contracted Provider, and transfers the Member to a contracted Provider, payment shall be made for Medically Necessary health care services furnished to the Member to maintain his or her stabilized condition up to the time that the Member's transfer is effectuated.

f. No Prior Authorization Request. If a non-contracted Provider does not seek a Prior Authorization request for Post-Stabilization Services from CalOptima or the Shared Risk Group, then CalOptima is only financially responsible for Emergency Services rendered, and not for Post-Stabilization Services.

3. The CalOptima Claims Department shall contact the CalOptima Utilization Management Department for clarification of any questions regarding an authorization of Post-Stabilization Services using the internal routing process.

~~H.~~I. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

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.1002: CalOptima Medi-Cal Fee Schedule
C. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.2011: Directed Payments
F. CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy HH.2022Δ: Record Retention and Access
J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
~~K.~~L. Title 22 California Code of Regulations, §§51002, 55000 and 55140(a)
M. Title 28, California Code of Regulations, §1300.71.4
~~L.~~N. Title 42 Code of Federal Regulations, §422.113(c~~)(3~~)
~~M.~~O. Title 42 United States Code, §1396u-2(h)(2)(C)

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~~N.~~P. Social Security Act, §1932(b)(2)(D)
~~O.~~Q. California Welfare and Institutions Code, §14105.28
~~P.~~R. California Health and Safety Code, §1797.1
~~Q.~~S. Manual of Current Procedural Terminology (CPT®), American Medical Association
~~R.~~T. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
~~S.~~U. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
~~T.~~V. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
~~U.~~W. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
~~V.~~X. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
~~W.~~Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives
~~X.~~Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services
~~Y.~~AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020
~~Z.~~BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2009	Department of Health Care Services (DHCS)	Approved as Submitted
03/10/2014	Department of Health Care Services (DHCS)	Approved as Submitted
07/06/2016	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
12/04/2020	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/04/2002	Regular Meeting of the CalOptima Board of Directors
06/05/2007	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
10/02/2008	Regular Meeting of the CalOptima Board of Directors
11/06/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/06/2019	Regular Meeting of the CalOptima Board of Directors

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06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/04/2020	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	TBD	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

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IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated by Indian Health Care ~~providers~~Providers with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.

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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 ~~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.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

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Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	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.
Indian Health Care Provider (IHCP)	As set forth in 42 CFR § 438.14 (a), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC § 1603).
Medically Necessary or Medical Necessity	-Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).

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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.
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.
Post-Stabilization Services	Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on CalOptima for a CalOptima Direct Member or on CalOptima and the Shared Risk Group for a Member enrolled in that Shared Risk Group for which CalOptima is financially responsible for the Covered Services in accordance with the Division of Financial Responsibility.
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), Licensed Midwife, Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.
Rural Health Clinic	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.

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Term	Definition
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Tribal Federally Qualified Health Center Provider or Tribal FHQC Provider	An Indian Health Care Provider operating under the authority of the Tribal Indian Self-Determination and Education Assistance Act and participating in Medi-Cal as a Tribal FQHC (using CMS criteria). California State Plan Amendment (SPA) 20-0044 establishes Tribal FQHCs provider type in Medi-Cal.

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Policy:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy outlines CalOptima's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Non-contracted hospitals, non-contracted Practitioners, and non-contracted Ancillary Service Providers shall not be eligible to participate in any CalOptima incentive payment programs.

B. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

C. CalOptima shall recover, or reimburse, overpayments in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

III. PROCEDURE

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima shall reimburse a hospital that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, as follows:

1. Contracted Hospital: CalOptima's reimbursement to a CalOptima Contracted Hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CCN or a Member Enrolled in a Shared Risk Group.

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2. Non-Contracted Hospital: CalOptima's reimbursement to a non-contracted hospital for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Shared Risk Group's Prior Authorization policies, is as follows:

   a. Outpatient Emergency and Non-Emergency Services: CalOptima shall reimburse non-contracted outpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

   b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

      i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

   c. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima and a hospital, CalOptima shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

      i. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

   d. Out of State Hospitals: Except as provided in Section III.A.2.d.i. of this Policy, CalOptima shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code, for dates of service on or after July 1, 2013.

      i. Border Hospitals: CalOptima shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: CalOptima shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community

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Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

4. If a Member changes Health Networks, including CalOptima Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this Policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Medi-Cal program. Subject to all applicable CalOptima Claims and Utilization Management (UM) policies, CalOptima shall reimburse a Practitioner providing Covered Services to a Member as follows:

1. Contracted Practitioner: CalOptima shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima.

2. Non-contracted Practitioner: CalOptima's reimbursement to a non-contracted Practitioner for Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, shall be based on the following:

a. Emergency Services: CalOptima shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. Non-Emergency Services: CalOptima shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible on a fee-for-service basis as follows:

i. For dates of service on or after January 1, 2011, CalOptima shall reimburse professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. Except as otherwise provided in this subsection, CalOptima shall reimburse a physician who is a California Children's Service (CCS) Program-paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent (140%) of the CalOptima Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

iii. CalOptima shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

iv. CalOptima shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

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v. CalOptima shall reimburse injectables at one hundred percent 100% of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vi. For dates of service on or after January 1, 2011, CalOptima shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vii. CalOptima shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a) CalOptima shall reimburse a provider, including a non-contracted provider, for a (12)-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a Member's request by a qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife and licensed midwives services as permitted within each practitioner's scope of practice, CalOptima shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an FQHC that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible, as follows:

1. Contracted FQHC: CalOptima shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima. CalOptima's contracted rates for an FQHC shall not be less than CalOptima's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

a. CalOptima shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

i. CalOptima shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same

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amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

ii. CalOptima shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Indian Health Service Facility that provides Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima is financially responsible as follows:

1. Contracted American Indian Health Service Program:

a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, CalOptima shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and CalOptima and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima, CalOptima shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima shall ensure that the following criteria are met for receipt of payments:

a. The American Indian Health Service Program provider must be identified by DHCS;

b. Service must be a Covered Service included in CalOptima's contract with DHCS;

c. Except as provided in Section III.E.5. of this Policy, only one rate payment per day, per category, shall be allowed within the following three (3) categories as set forth in the California Medicaid State Plan Supplement 6. Attachment 4.19-B. This allows for a maximum of three (3) payments per day, one (1) from each category:

i. Medical health visit;

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ii. Mental health visit;

iii. Ambulatory visit.

5. Tribal FQHC: Effective January 1, 2021, CalOptima shall reimburse a Tribal FQHC Provider, including an Indian Health Care Provider enrolled as an Indian Health Services Memorandum of Agreement (IHS-MOA) clinic that elected to participate in Medi-Cal as a Tribal FQHC Provider in accordance with the Alternate Payment Methodology (APM), which is set at the All-Inclusive Rate (AIR). Once enrolled with DHCS, the DHCS will add the new Trial FQHC Provider and the following reimbursement requirements:

a. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent (80%) of the Medicare FQHC prospective payment system rate.

b. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."

c. CalOptima shall ensure that the following criteria are met for receipt of payments:

i. The Tribal FQHC provider must be identified by DHCS;

ii. Service must be a Covered Service included in CalOptima's contract with DHCS;

iii. As set forth in DHCS All Plan Letter 21-008: Tribal Federally Qualified Health Center Providers and California State Plan Amendment to Attachment 4.19-B, CA-20-0044, a Tribal FQHC Provider shall be reimbursed at the applicable rate for up to three (3) visits per day, per Member in any combination of different visits in the following visit categories:

1) Medical health visit;

2) Mental health visit; and

3) Ambulatory visit.

d. . A Tribal FQHC Provider may expand its service locations outside of the clinic facility when services are provided by clinic providers or provider contracting with the Tribal FQHC Provider.

6. Certain Covered Services shall be reimbursed outside of the OMB or APM rate, including Non-Medical Transportation, Non-Emergency Medical Transportation, and pharmacy services.

F. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible as follows:

1. CalOptima shall reimburse a contracted Ancillary Service Provider based on the terms and conditions of the contract between such contracted Ancillary Service Provider and CalOptima.

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2. CalOptima shall reimburse a non-contracted Ancillary Service Provider for Covered Services rendered to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group, at one hundred percent (100%) of the CalOptima Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

G. Directed Payment: CalOptima shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for which CalOptima is financially responsible, in accordance with the requirements of CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to a Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services.

H. Financial Responsibility for Medically Necessary Post-Stabilization Services: Subject to compliance with all applicable Claims policies and Utilization Management (UM) policies, including but not limited to, authorization, medical records, coding and billing requirements, CalOptima's financial responsibility for Medically Necessary Post-Stabilization Services provided to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group are as follows:

1. Contracted Provider: CalOptima is financially responsible for Medically Necessary Post-Stabilization Services rendered by a contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group in accordance with their contract.

2. Non-Contracted Provider:

a. CalOptima is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group that are:

i. Pre-approved by CalOptima or the Shared Risk Group, as applicable.

ii. Not pre-approved by CalOptima or the Shared Risk Group, as applicable, but administered to maintain the Member's stabilized condition within one (1) hour of a request to CalOptima or the Shared Risk Group for Prior Authorization of further Post-Stabilization Services.

b. CalOptima is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group that are not pre-approved by CalOptima or the Shared Risk Group, as applicable, but administered to maintain, improve, or resolve the Member's stabilized condition if:

i. CalOptima or the Shared Risk Group, as applicable, does not respond within thirty (30) minutes after receipt of a written request for Prior Authorization for Medically Necessary Post-Stabilization Services, that fully complies with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable;

ii. CalOptima or the Shared Risk Group, as applicable, cannot be contacted; or

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iii. A representative of CalOptima or the Shared Risk Group, as applicable, and the treating physician cannot reach an agreement concerning the Member's care, and CalOptima or the Shared Risk Group's plan physician is not available for consultation. In this situation, CalOptima or the Shared Risk Group must give the treating physician the opportunity to consult with CalOptima or the Shared Risk Group's plan physician, as applicable, and the treating physician may continue with care of the Member until such plan physician is reached or one (1) of the criteria in 42 C.F.R. § 422.113(c)(3) is met, as set forth in Section III.H.2.d of this Policy.

c. Notwithstanding Section III.H.2.b.i. of this Policy, CalOptima has the authority to disapprove payment for the delivery of Post-Stabilization Services or the continuation of the delivery of Post-Stabilization Services, if CalOptima or the Shared Risk Group notifies the non-contacted Provider of the denial of a request prior to the commencement of the delivery or during the delivery of Post-Stabilization Services in accordance with the requirements of CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable. In that event and subject to Section III.H.3.c.i. of this Policy, CalOptima shall not be obligated to pay for the continuation of Post-Stabilization Services from and after the time CalOptima or the Shared Risk Group, as applicable, provides such notice.

i. CalOptima shall pay for all Medically Necessary health care services provided to a Member which are necessary to maintain the Member's stabilized condition up to the time that CalOptima or the Shared Risk Group, as applicable, effectuates the Member's transfer or the Member is discharged.

d. CalOptima's financial responsibility for Medically Necessary Post-Stabilization Services not pre-approved ends when:

i. CalOptima or the Shared Risk Group's plan physician, as applicable, with privileges at the treating hospital assumes responsibility for the Member's care;

ii. CalOptima or the Shared Risk Group's plan physician, as applicable, assumes responsibility for the Member's care through transfer;

iii. A representative of CalOptima or the Shared Risk Group, as applicable, and the treating physician reach an agreement concerning the Member's care; or

iv. The Member is discharged.

e. Denial and Transfer: In the event that CalOptima or a Shared Risk Group denies a Prior Authorization request for Post-Stabilization Services from a non-contracted Provider, and transfers the Member to a contracted Provider, payment shall be made for Medically Necessary health care services furnished to the Member to maintain his or her stabilized condition up to the time that the Member's transfer is effectuated.

f. No Prior Authorization Request. If a non-contracted Provider does not seek a Prior Authorization request for Post-Stabilization Services from CalOptima or the Shared Risk Group, then CalOptima is only financially responsible for Emergency Services rendered, and not for Post-Stabilization Services.

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3. The CalOptima Claims Department shall contact the CalOptima Utilization Management Department for clarification of any questions regarding an authorization of Post-Stabilization Services using the internal routing process.

I. A Provider or Practitioner that renders Covered Services to a Member of CalOptima Direct or a Member enrolled in a Shared Risk Group for Covered Services for which CalOptima is financially responsible shall submit claims to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

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.1002: CalOptima Medi-Cal Fee Schedule
C. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
E. CalOptima Policy FF.2011: Directed Payments
F. CalOptima Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members when CalOptima is Financially Responsible for the Qualifying Services
G. CalOptima Policy GG.1116: Pediatric Preventive Services
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy HH.2022Δ: Record Retention and Access
J. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
K. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
L. Title 22 California Code of Regulations, §§51002, 55000 and 55140(a)
M. Title 28, California Code of Regulations, §1300.71.4
N. Title 42 Code of Federal Regulations, §422.113(c)
O. Title 42 United States Code, §1396u-2(h)(2)(C)
P. Social Security Act, §1932(b)(2)(D)
Q. California Welfare and Institutions Code, §14105.28
R. California Health and Safety Code, §1797.1
S. Manual of Current Procedural Terminology (CPT®), American Medical Association
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
V. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
W. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American

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Indian Health Programs

Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives

Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services

AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020

BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2009	Department of Health Care Services (DHCS)	Approved as Submitted
03/10/2014	Department of Health Care Services (DHCS)	Approved as Submitted
07/06/2016	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
12/04/2020	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/04/2002	Regular Meeting of the CalOptima Board of Directors
06/05/2007	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
10/02/2008	Regular Meeting of the CalOptima Board of Directors
11/06/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/06/2019	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	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	06/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/04/2020	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	TBD	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

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IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated by Indian Health Care Providers with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.

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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 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.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

For 20220505 BOD Review Only

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	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.
Indian Health Care Provider (IHCP)	As set forth in 42 CFR § 438.14 (a), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC § 1603).
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).

For 20220505 BOD Review Only

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.
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.
Post-Stabilization Services	Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on CalOptima for a CalOptima Direct Member or on CalOptima and the Shared Risk Group for a Member enrolled in that Shared Risk Group for which CalOptima is financially responsible for the Covered Services in accordance with the Division of Financial Responsibility.
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), Licensed Midwife, Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.
Rural Health Clinic	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.

For 20220505 BOD Review Only

Term	Definition
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Tribal Federally Qualified Health Center Provider or Tribal FHQC Provider	An Indian Health Care Provider operating under the authority of the Tribal Indian Self-Determination and Education Assistance Act and participating in Medi-Cal as a Tribal FQHC (using CMS criteria). California State Plan Amendment (SPA) 20-0044 establishes Tribal FQHCs provider type in Medi-Cal.

For 20220505 BOD Review Only

Policy:	FF.2004
Title:	**Financial Responsibility for Newborn Coverage**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/27/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy clarifies the financial responsibility for ~~coverage of~~Covered Services provided to a Newborn, if the ~~Newborn does not have eligibility through his~~mother is eligible for Medi-Cal and enrolled in CalOptima Direct or ~~her own Client Index Number (CIN).~~a Health Network.

II. POLICY

A. If a mother of Newborn is a ~~Health Network~~CalOptima Direct Member ~~and the Newborn does not have eligibility through his or her own CIN, the Health Network~~, CalOptima Direct shall ~~remain~~be financially responsible for Covered Services ~~for~~provided to the Newborn ~~until~~as follows:

1. California Children's Services (CCS) Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU) eligible Newborns: Through the second month of life, on a fee-for-service basis.

~~1.~~2. Newborns not receiving CCS NICU or PICU Services: Until the Newborn receives a Client Index Number (CIN) from the Social Services Agency (SSA~~)~~), or through the ~~month following the~~second month of ~~birth (Month Two),~~life, whichever is earlier~~.~~, on a fee-for-service basis, for Non-CCS NICU or PICU services.

B. Capitation Payments made to a Health Network for Covered Services to the mother represent payment in full for Covered Services ~~for~~provided to the Newborn.

C. ~~If~~ a mother of a Newborn is a ~~CalOptima Direct~~Health Network Member ~~during,~~ the ~~month of birth (Month One) and Month Two, and the Newborn does not have eligibility through his or her own CIN, CalOptima Direct~~ Health Network shall ~~remain~~be financially responsible for Covered Services ~~for~~ provided to the Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Through the ~~Newborn until~~second month of life.

~~1.~~2. Newborns not receiving CCS NICU or PICU Services: Until the Newborn receives a CIN from SSA~~,~~ or through ~~Month Two, on a fee-for-service basis, using~~ the ~~mother's CIN.~~second month of life, whichever is earlier.

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~~C.~~D. If a Newborn does not have a CIN after ~~Month Two~~the second month of life, CalOptima~~,~~ or a Health Network~~,~~ shall not be responsible ~~to provide~~for Covered Services ~~for~~provided to the Newborn.

~~D.~~E. CalOptima shall enroll the Newborn in a Health Network upon receipt of a CIN from the ~~Social Services Agency~~SSA, in accordance with CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process and AA.1207a: CalOptima Auto-Assignment ~~and DD.2008: Health Network Selection.~~

III. PROCEDURE

A. If ~~the~~a mother of Newborn ~~does not have a CIN~~is a CalOptima Direct Member, a Provider~~,~~ or Practitioner~~,~~ shall bill for ~~Newborn~~ Covered Services ~~under~~provided to a Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Using the mother's CIN for the first two (2) months of life.

~~1.~~2. Newborns not receiving CCS NICU or PICU Services: Using the mother's CIN for the first two (2) months of life, or until the Newborn ~~receives a~~is issued their own CIN ~~from the SSA, or for a maximum period of Month One and Month Two~~.

B. ~~After Month Two~~If a mother of a Newborn is a Health Network Member, a Provider~~,~~ or Practitioner~~,~~ shall ~~not~~ bill for ~~Newborn~~ Covered Services ~~under~~provided to a Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Using the mother's CIN for the first two (2) months of life.

2. Newborns not receiving CCS NICU or PICU Services: Using the mother's CIN for the first two (2) months of life, or until the Newborn is issued their own CIN.

C. After the first two (2) months of life, a Provider or Practitioner shall not bill for Covered Services provided to a Newborn under the mother's CIN.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-005 (revised): California Children's Whole Child Model Program (supersedes APL 18-023)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

For 20220505 BOD Review Only

03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted

~~None to Date~~

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/1995	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	11/01/1997	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2007	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	11/01/2016	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2018	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2019	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	08/01/2020	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	TBD	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal

For 20220505 BOD Review Only

IX. GLOSSARY

Term	Definition
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
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Client Index Number (CIN)	For the purposes of this policy, refers to the unique 9-digit number assigned to eligible Members enrolled in the Medi-Cal program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), 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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Newborn ~~Child~~	Means a child under the age of one (1) who was born to a Member during her membership or the month prior to her membership.

For 2022-05 COD 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), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician~~, pharmacist~~, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ~~health maintenance organization, Physician Medical Group~~ancillary provider, or other person or institution who furnishes Covered Services.

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For 20220505 BOD Review Only

Policy:	FF.2004
Title:	**Financial Responsibility for Newborn Coverage**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/27/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy clarifies the financial responsibility for Covered Services provided to a Newborn, if the mother is eligible for Medi-Cal and enrolled in CalOptima Direct or a Health Network.

II. POLICY

A. If a mother of Newborn is a CalOptima Direct Member, CalOptima Direct shall be financially responsible for Covered Services provided to the Newborn as follows:

1. California Children's Services (CCS) Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU) eligible Newborns: Through the second month of life, on a fee-for-service basis.

2. Newborns not receiving CCS NICU or PICU Services: Until the Newborn receives a Client Index Number (CIN) from the Social Services Agency (SSA), or through the second month of life, whichever is earlier, on a fee-for-service basis, for Non-CCS NICU or PICU services.

B. Capitation Payments made to a Health Network for Covered Services to the mother represent payment in full for Covered Services provided to the Newborn.

C. If a mother of a Newborn is a Health Network Member, the Health Network shall be financially responsible for Covered Services provided to the Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Through the second month of life.

2. Newborns not receiving CCS NICU or PICU Services: Until the Newborn receives a CIN from SSA or through the second month of life, whichever is earlier.

D. If a Newborn does not have a CIN after the second month of life, CalOptima or a Health Network shall not be responsible for Covered Services provided to the Newborn.

E. CalOptima shall enroll the Newborn in a Health Network upon receipt of a CIN from the SSA, in accordance with CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process and AA.1207a: CalOptima Auto-Assignment.

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III. PROCEDURE

A. If a mother of Newborn is a CalOptima Direct Member, a Provider or Practitioner shall bill for Covered Services provided to a Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Using the mother's CIN for the first two (2) months of life.

2. Newborns not receiving CCS NICU or PICU Services: Using the mother's CIN for the first two (2) months of life, or until the Newborn is issued their own CIN.

B. If a mother of a Newborn is a Health Network Member, a Provider or Practitioner shall bill for Covered Services provided to a Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Using the mother's CIN for the first two (2) months of life.

2. Newborns not receiving CCS NICU or PICU Services: Using the mother's CIN for the first two (2) months of life, or until the Newborn is issued their own CIN.

C. After the first two (2) months of life, a Provider or Practitioner shall not bill for Covered Services provided to a Newborn under the mother's CIN.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
D. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-005 (revised): California Children's Whole Child Model Program (supersedes APL 18-023)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/1995	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	11/01/1997	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2007	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal

For 20220505 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2016	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2018	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2019	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	08/01/2020	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	TBD	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal

For 20220505 BOD Review Only

IX. GLOSSARY

Term	Definition
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
Capitation Payment	The monthly amount paid to a Health Network by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Client Index Number (CIN)	For the purposes of this policy, refers to the unique 9-digit number assigned to eligible Members enrolled in the Medi-Cal program.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), 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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Newborn	Means a child under the age of one (1) who was born to a Member during her membership or the month prior to her membership.
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), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

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Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution who furnishes Covered Services.

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Policy:	FF.2011
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy establishes requirements pursuant to which a Health Network shall administer the Directed Payments for Qualifying Services, and processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A and, as applicable, Attachment B of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) Approved Preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

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6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, a Health Network shall further ensure that the VBP measures and the ICD-10 Codes reported are appropriate for the services being provided as well as any other data requested by CalOptima.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e., Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

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2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.
   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. ~~a.~~ Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), cost-based reimbursement clinics, American Indian Health Services Programs, and ~~cost-based reimbursement clinics~~Indian Health Care Providers (IHCP) including: Indian Health Services Memorandum of Agreement (IHS-MOA) clinics, FQHCs, Tribal FQHCs, and community clinics, are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering

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Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

a. The following Developmental Screening Services are eligible for an Add-On Payment:

   i. A routine screening when provided:

      1) On or before the first birthday (twelve (12) months);

      2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

      3) After the second birthday and on or before the third birthday (thirty-six (36) months).

   ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

      1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

      2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

   i. The tool that was used to perform the Developmental Screening Service;

   ii. That the completed screen was reviewed;

   iii. The interpretation of results;

   iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

   v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, a Health Network shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

   a. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

   b. Family Planning Services are not subject to any prior authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, a Health Network shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

   a. An Add-On Payment for qualifying VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

      i. Possess an individual (Type 1) National Provider Identifier (NPI); and

      ii. Are practicing within their practice scope.

   b. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

   c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, a Health Network shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, a Health Network shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

5. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

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ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. ~~i.~~ The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance or post-payment recovery, in accordance with its contractual obligations to CalOptima.

7. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

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a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

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b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

b. ~~c.~~ If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

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1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment report(s) in accordance with Section III.D. of this Policy.

    a. Excluding the VBP Program, the CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

    b. For the VBP Program, on a monthly basis, CalOptima's Quality Analytics Department shall provide a report to each Health Network via the secure file transfer protocol (sFTP).

        i. The report will include at minimum, a list of:

            1) Qualified providers that satisfy the requirements of Section III.A.4. of this Policy;

            2) Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

            3) Directed Payment amounts.

        ii. CalOptima Quality Analytics Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to sending the report to the CalOptima Accounting Department to make a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

    c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit Directed Payment adjustment report(s) for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit such adjustment report(s) in accordance with CalOptima's requirements and using CalOptima's proprietary format and file naming convention, as set forth in CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

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2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims;

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services; or

   c. For the VBP Program, the Estimated Initial Month Payment shall be based upon data provided by CalOptima Quality Analytics Department to CalOptima Accounting Department.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

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G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (*i.e.*, the Member's Health Network that is financially responsible for the specified Directed Payment,), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised ~~07/01/2020~~TBD)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
H. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
I. State Plan Amendment (SPA) 21-0017: One-Year Reimbursement Rate Add-on for Eligible Ground Emergency Medical Transport Services
~~I.~~J. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
~~J.~~K. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
~~K.~~L. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
~~L.~~M. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
~~M.~~N. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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~~N.~~O. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
~~O.~~P. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
~~P.~~Q. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
~~Q.~~R. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
S. Department of Health Care Services All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
~~R.~~T. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/10/2020	Department of Health Care Services (DHCS)	File and Use
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular 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	04/02/2020	FF.2011	Directed Payments	Medi-Cal
Revised	05/01/2020	FF.2011	Directed Payments	Medi-Cal
Revised	12/03/2020	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	TBD	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	~~Directed~~An Add-On Payment ~~that funds a supplemental payment for certain Qualifying Services at a rate set forth~~or Minimum Fee Payment required by DHCS ~~that is in addition~~ to ~~any other payment, fee-for-service or capitation, a specified~~ be made to a Designated Provider ~~receives from a Health Network.~~for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangements for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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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 ~~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~~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.
Department of Health Care Services (DHCS)	The ~~state department in California~~ single State Department responsible for administration of the ~~federal Medicaid~~Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (~~referred to as~~ GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.~~Medi-Cal in California).~~
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, ~~Developmental Screening~~and Abortion Services~~, and VBP Program Services;~~; ~~2.~~ Eligible Contracted Providers ~~and non-contracted Providers~~ that are ~~Family Planning Providers for Family Planning~~FQHCs, RHCs, and Indian Health Services~~;~~ ~~3.~~2. ~~Eligible Contracted Providers and non-contracted Providers~~ Memorandum of Agreement (IHS-MOA) 638 clinics for ~~Abortion~~Developmental Screening Services; ~~and~~ 3. Non-contracted GEMT Providers for GEMT Services~~.~~; and 4. Non-contracted Providers for Abortion Services.

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Term	Definition
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as set forth in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.

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Term	Definition
Federally Qualified Health Center (FQHC)	~~A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.~~An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
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 ~~Medi-Cal~~ Members ~~receiving managed long term services and support (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 the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards~~ set forth in ~~42 U.S.C.~~ Section 1396d(r~~) and California Welfare~~)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and ~~Institutions~~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.

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Term	Definition
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	~~An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.~~An entity defined in Title 22 CCR Section 51115.5.
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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Policy:	FF.2011
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy establishes requirements pursuant to which a Health Network shall administer the Directed Payments for Qualifying Services, and processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A and, as applicable, Attachment B of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) Approved Preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

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6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, a Health Network shall further ensure that the VBP measures and the ICD-10 Codes reported are appropriate for the services being provided as well as any other data requested by CalOptima.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e., Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

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2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.
   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), cost-based reimbursement clinics, American Indian Health Services Programs, and Indian Health Care Providers (IHCP) including: Indian Health Services Memorandum of Agreement (IHS-MOA) clinics, FQHCs, Tribal FQHCs, and community clinics, are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering

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Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

a. The following Developmental Screening Services are eligible for an Add-On Payment:

   i. A routine screening when provided:

      1) On or before the first birthday (twelve (12) months);

      2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

      3) After the second birthday and on or before the third birthday (thirty-six (36) months).

   ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

      1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

      2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

   i. The tool that was used to perform the Developmental Screening Service;

   ii. That the completed screen was reviewed;

   iii. The interpretation of results;

   iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

   v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

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f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, a Health Network shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

   a. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

   b. Family Planning Services are not subject to any prior authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, a Health Network shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

   a. An Add-On Payment for qualifying VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

      i. Possess an individual (Type 1) National Provider Identifier (NPI); and

      ii. Are practicing within their practice scope.

   b. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

   c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, a Health Network shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, a Health Network shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

5. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

   a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

      i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

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ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance or post-payment recovery, in accordance with its contractual obligations to CalOptima.

7. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

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a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year from the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.*, between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

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b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

b. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

i. The Member has other sources of health coverage;

ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

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1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment report(s) in accordance with Section III.D. of this Policy.

    a. Excluding the VBP Program, the CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

    b. For the VBP Program, on a monthly basis, CalOptima's Quality Analytics Department shall provide a report to each Health Network via the secure file transfer protocol (sFTP).

        i. The report will include at minimum, a list of:

            1) Qualified providers that satisfy the requirements of Section III.A.4. of this Policy;

            2) Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

            3) Directed Payment amounts.

        ii. CalOptima Quality Analytics Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to sending the report to the CalOptima Accounting Department to make a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

    c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit Directed Payment adjustment report(s) for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit such adjustment report(s) in accordance with CalOptima's requirements and using CalOptima's proprietary format and file naming convention, as set forth in CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

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2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims;

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services; or

   c. For the VBP Program, the Estimated Initial Month Payment shall be based upon data provided by CalOptima Quality Analytics Department to CalOptima Accounting Department.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

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G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (*i.e.*, the Member's Health Network that is financially responsible for the specified Directed Payment,), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

    a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

    b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised TBD)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
H. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
I. State Plan Amendment (SPA) 21-0017: One-Year Reimbursement Rate Add-on for Eligible Ground Emergency Medical Transport Services
J. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
K. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
L. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
M. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
N. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

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O. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
P. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
Q. Department of Health Care Services All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
R. Department of Health Care Services All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
S. Department of Health Care Services All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
T. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/10/2020	Department of Health Care Services (DHCS)	File and Use
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular 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	04/02/2020	FF.2011	Directed Payments	Medi-Cal
Revised	05/01/2020	FF.2011	Directed Payments	Medi-Cal
Revised	12/03/2020	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal
Revised	TBD	FF.2011	Directed Payments for Qualifying Services Rendered to CalOptima Health Network Members When Health Networks are Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangements for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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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 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.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.

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Term	Definition
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as set forth in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
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)).
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.

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Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
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	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.

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Term	Definition
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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For 2022 BOD Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

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[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]*At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.*

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code[5]	Description	Minimum Fee Payment[65]
59840	Induced abortion, by dilation and curettage	$400.00
~~59840~~	~~Induced abortion, by dilation and curettage~~	~~$400.00~~
~~59841~~	~~Induced abortion, by dilation and evacuation~~	~~$700.00~~
59841	Induced abortion, by dilation and evacuation	$700.00

[5] *Inclusive of both K and O Procedure Types*

[65] *Payment obligations for rates of at least $400 and $700 for eligible service codes*

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Sources**: State Plan Amendment (SPA) 20-0009; ~~State Plan Amendment~~SPA ~~19-0020~~ 21-0017; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 -- ~~June 30, 2021~~0 June 30, 2022

CPT Code	Description	Minimum Fee Payment[76]			
		SFY 18-19	SFY 19-20~~10~~	SFY 2~~10~~-2~~12~~	SFY 21-22
A0429	Basic Life Support, Emergency	$339.00	$339.00	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00	$339.00	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72	$400.72	$400.72

[76] *Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

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[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]*At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code[5]	Description	Minimum Fee Payment[6]
59840	Induced abortion, by dilation and curettage	$400.00
59841	Induced abortion, by dilation and evacuation	$700.00

[5]*Inclusive of both K and O Procedure Types*

[6]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Sources**: State Plan Amendment (SPA) 20-0009; SPA 21-0017; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 - June 30, 2022

CPT Code	Description	Minimum Fee Payment[7]			
		SFY 18-19	SFY 19-20	SFY 20-21	SFY 21-22
A0429	Basic Life Support, Emergency	$339.00	$339.00	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00	$339.00	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72	$400.72	$400.72

[7]*Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

The Department of Health Care Services (DHCS) is providing the measure specifications for the Value-Based Payment (VBP) Program measures. DHCS may make technical updates to VBP measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) Core Set measure specifications.

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Prenatal/Postpartum Care

Prenatal Pertussis ('Whooping Cough') Vaccine

Incentive payment to the provider for the administration of the pertussis vaccination to women who are pregnant

- Payment to rendering or prescribing provider for Tdap vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

This measure supports the Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Immunization Status measure. The measure looks at the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial prenatal visit

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis - not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a 992xx CPT code on the encounter

DHCS understands that women may change providers and plans during a pregnancy. Therefore, the first visit that occurs in a specific plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship.

This measure supports the Centers for Medicare and Medicaid (CMS) Child Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH). The Measure PPC-CH measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/Children's Health Insurance Program (CHIP).

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Postpartum Care Visits

Incentive payment for completion of recommended postpartum care visits after a woman gives birth

- Payment to rendering provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by the use of the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

Definitions

Early Postpartum Visit	A postpartum visit on or between 1 and 21 days after delivery
Late Postpartum Visit	A postpartum visit on or between 22 and 84 days after delivery

Incentive payments support the current American College of Obstetricians and Gynecologists recommendations regarding the two postpartum visits. DHCS expects that nationally utilized quality metrics will eventually align with the current clinical recommendations. The current CMS Adult Core Set Prenatal and Postpartum Care: Postpartum Care (PPC-AD) measure is expected to align with this in the future. The current Measure PPC-AD measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Postpartum Birth Control

Incentive payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

The codes used to calculate this measure are available in Tables CCP-C through CCPD at:

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https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-ofcare%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

This measure supports CMS Child and Adult Core Set Measures Contraceptive Care - Postpartum Measures (CCP-CH) (ages 15-20) and (CCP-AD) (ages 21-44) The Measure CCP measures among women who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Early Childhood

Well Child Visits in First 15 Months of Life

Separate incentive payment to a provider for each of the last three well child visits out of eight total - 6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months)

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6 month visit – the first well care visit between 172 and 263 days of life
  - 9 month visit – the first well care visit between 264 and 355 days of life
  - 12 month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for payment • Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
  - ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the First 15 Months of Life (W15-CH). The Measure W15-CH measures the percentage of children who turned 15 months old during the measurement year and who had six or more wellchild visits with a primary care practitioner during their first 15 months of life.

Well Child Visits in 3rd – 6th Years of Life

Separate payment to each rendering provider for successfully completing each of the annual well child visits at age 3, 4, 5, and 6

- Payment for the first well child visit in each year age group (3, 4, 5, or 6 year olds)
- Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439

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- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH). The Measure W34-CH measures the percentage of children ages three to six who had one or more well-child visits with a primary care practitioner during measurement year.

All Childhood Vaccines for Two Year Olds

For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient
- A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

This measure supports the CMS Child Core Set Childhood Immunization Status (CISCH). The Measure CIS-CH measures the percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Blood Lead Screening

Incentive payment to a provider for completing a blood lead screening in children up to two years of age

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment

Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

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Dental Fluoride Varnish

Incentive payment to provider if provides oral fluoride varnish application for children 6 months through 5 years

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12 month period

Chronic Disease Management

Controlling High Blood Pressure

Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day • Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

- Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130) – CPT 3075F (systolic blood pressure less than 130-39)
- Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80) – CPT 3079F (diastolic blood pressure less than 80-89)
- Hypertension:
  - ICD-10: I10 (essential hypertension)

This measure supports CMS Adult Core Set Controlling High Blood Pressure (CBP-AD). The measure CBP-AD measures the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Diabetes Care

Incentive payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3045F most recent HbA1c 7.0-9.0% (through September 30, 2019)
  - CPT 3051F most recent HbA1c >= 7.0% and < 8.0% (as of October 1, 2019)

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  - CPT 3052F most recent HbA1c 8.0-9.0% (as of October 1, 2019)
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

This measure supports both CMS Adult Core Set measures HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD) The measure HA1C-AD assesses the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test, and the measure HPC-AD measures the percentage with an HbA1c level <9.0%.

Control of Persistent Asthma

Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit

The Asthma Value Set includes the following diagnosis codes:

J45.20 Mild intermittent asthma, uncomplicated
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus J45.909 Unspecified asthma, uncomplicated
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

This measure specification supports CMS Child and Adult Core Set measures Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD). These measures assess the percentage of beneficiaries ages 5-64 who were identified as having

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persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater.

Tobacco Use Screening

Incentive payment to provider for tobacco use screening or counseling provided to members 12 years and older

- Payment to rendering provider for any of the following CPT codes: 99406, 99407, 4004F, or 1036F (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco.

This measure aligns with U.S. Preventive Services Task Force (USPFTF) recommendations with regards to screening/counseling for tobacco

- Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Adolescents: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions

Adult Influenza ('Flu') Vaccine

Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

This measures supports the American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI) NQF 0041 Preventive Care and Screening: Influenza Immunization which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization.

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Screening for Clinical Depression

Incentive payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Followup Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days)
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major depression diagnosis codes	ICD10: F32.0,F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9

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Antidepressant medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndclicense/hedis-2019-final-ndc-lists/.

This measure supports the CMS Adult Core Set measure Antidepressant Medication Management (AMM-AD). The Measure AMM-AD Effective Acute Phase Treatment measures the percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication for at least 84 days (12 weeks).

Screening for Unhealthy Alcohol Use

Incentive payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older

- Payment to rendering provider for any of the following CPT codes: 99408, 99409, G0396, G0397, G0442, G0443, H0049, or H0050 (equivalent payment for all codes)
- No more than one payment per provider per patient per year

This measure specification supports Quality Identifier #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. The Measure NQF 2152 measures the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.

The measures aligns with USPFTF Recommendations with regards to alcohol screening tools:

- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioralcounseling-interventions

Overarching Payment Conditions

Data to be used to calculate payments:

- Medi-Cal administrative data reported through the Managed Care Plans encounter data
- Medi-Cal administrative data reported in the Medi-Cal Eligibility Data System
- For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source
- For the Blood Lead Screening measure, the expectation is that blood lead test results reported through the CDPH Blood Lead Registry may be used as a supplementary data source

Providers will be identified based on:

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- National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1)
- If the rendering or ordering is not filled, then look for prescribing provider field that is an NPI for an individual (Type 1)
- If the rendering, ordering, or prescribing is not filled, then look for billing provider that is an NPI for an individual (Type 1)
- To qualify for payment, providers must be practicing within their practice scope and must have an individual (Type 1) NPI. For example, if a pharmacist (not the pharmacy) provides an immunization, then that pharmacist could receive payment.

Beneficiary inclusion criteria:

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data

Beneficiary exclusion criteria:

- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, and Cost Based Reimbursement Clinics will be excluded from payment

An enhanced payment factor will be applied to the above services provided to beneficiaries with the following conditions:

- Substance Use Disorder (SUD) – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness (SMI) – CMS Core Set Measure Sets: Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set, and Major Depression Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement year. The diagnosis of homeless should be on the encounter data for the VBP eligible service.

Post utilization monitoring will be performed to ensure overuse of services is not occurring.

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Technical Updates to the Specifications

Updated in May 7, 2020 Version:

- Removed from the Diabetes measure the reference to the Hemoglobin A1c (HA1C-AD) Testing measure, which was removed from the CMS Adult Core Set in the 2020 reporting year (data collection year 2019).
- Adjusted the Diabetes measure to indicate CPT 3045F is valid through September 30, 2019 and is replaced with CPT 3051F and CPT 3052F as of October 1, 2019.
- Removed from the Tobacco Use Screening measure codes CPT G0436 and CPT G0437, which were retired September 30, 2016.
- Added to the Screening for Unhealthy Alcohol Use measure codes CPT G0442 and CPT G0443.

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Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	06/04/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to 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.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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3. The Designated Provider was eligible to receive the Directed Payment.
4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A and, as applicable, Attachment B of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, CalOptima shall further ensure that the VBP measures and ICD-10 Codes reported are appropriate for the services being provided.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or 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, as applicable.

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III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. ~~a.~~ Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), cost-based reimbursement clinics, American Indian Health Services Programs, and ~~cost-based reimbursement clinics~~Indian Health Care Providers (IHCP) including: Indian Health Services Memorandum of Agreement (IHS-MOA) clinics, FQHCs, Tribal FQHCs, and Community clinics, are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday (twelve (12) months);

         2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

         3) After the second birthday and on or before the third birthday (thirty-six (36) months).

      ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

         1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

         2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

   b. Development Screening Services are not subject to any Prior Authorization requirements.

   c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

   d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

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i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, CalOptima shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

a. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

b. Family Planning Services are not subject to any Prior Authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, CalOptima shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

a. An Add-On Payment for VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

i. Possess an individual (Type 1) National Provider Identifier (NPI); and

ii. Are practicing within their practice scope.

b. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, CalOptima shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, CalOptima shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

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d. CalOptima's Quality Analytics Department shall develop a monthly report to process payments which will include, at minimum, a list of:

i. Eligible Contracted Providers that satisfy the requirements of this Section III.A.4 of the Policy;

ii. Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

iii. Add-On Payment amount(s).

5. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

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d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

   a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

7. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

   a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

   b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by CalOptima no later than one (1) year from the date of service.

   a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

   b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

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2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.
   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

   1. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

   2. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

   a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

      i. The Member has other sources of health coverage;

      ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

      iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

      iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative

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Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

   a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

   b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised ~~07/01/2020~~TBD)
B. ~~B.~~ VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~B. CalOptima Policy AA.1000: Medi-Cal Glossary of Terms~~
~~C.~~B. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
~~D.~~C. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
~~E.~~D. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
~~F.~~E. 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
~~G.~~F. CalOptima Policy FF.2003: Coordination of Benefits
~~H.~~G. CalOptima Policy FF.2011: Directed Payments
~~I.~~H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~J.~~I. CalOptima Policy GG.1116: Pediatric Preventive Services
~~K.~~J. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~L.~~K. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
~~M.~~L. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
~~N.~~M. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program

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N. State Plan Amendment (SPA) 21-0017: One-Year Reimbursement Rate Add-on for Eligible Ground Emergency Medical Transport Services
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
~~X.~~Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
~~Y.~~Z. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

~~None to Date~~

Date	Regulatory Agency	Response
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of CalOptima Board of Directors
12/03/2020	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	12/03/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
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.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

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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 ~~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.
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.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, ~~Developmental Screening~~and Abortion Services~~, and VBP Program Services;~~; ~~2.~~ Eligible Contracted Providers ~~and non-contracted Providers~~ that are ~~Family Planning Providers for Family Planning~~FQHCs, RHCs, and Indian Health Services~~;~~ ~~3.~~2. ~~Eligible Contracted Providers and non-contracted Providers~~ Memorandum of Agreement (IHS-MOA) 638 clinics for ~~Abortion~~Developmental Screening Services; ~~and~~ 3. Non-contracted GEMT Providers for GEMT Services~~.~~; and 4. Non-contracted Providers for Abortion Services. ~~4.~~5.

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Term	Definition
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as specified in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Federally Qualified Health Center (FQHC)	~~A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.~~An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).

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Term	Definition
Ground Emergency Medical Transport (GEMT) Services	~~For purposes of this Policy, specified~~ Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary 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 support (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 the Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards~~ set forth in ~~42 U.S.C.~~ Section 1396d(r~~) and California Welfare~~)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and ~~Institutions~~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	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.

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Term	Definition
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	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 ~~or procedures.~~, except in the case of an emergency.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	~~An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services~~An entity defined in Title 22 CCR Section 51115.5.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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Policy:	FF.2012
Title:	**Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	06/04/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima shall administer Directed Payments for Qualifying Services rendered to CalOptima Direct or Shared Risk Group Members. For Qualifying Services rendered to Shared Risk Group Members, this Policy shall only apply to Directed Payments for Ground Emergency Medical Transport (GEMT) Services for which CalOptima is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process and pay Directed Payments for Qualifying Services to a Designated Provider in compliance with this Policy, and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare and Medicaid Services (CMS) Approved Preprint.

B. A Designated Provider shall qualify for reimbursement of Directed Payments for Qualifying Services if the requirements of this Policy are met. These requirements include, but are not limited to, the following:

1. The Qualifying Services were eligible for reimbursement (e.g., based on coverage, coding, and billing requirements), in accordance with all applicable CalOptima claims and utilization management policies, including but not limited to 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.

2. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was enrolled in CalOptima Direct or a Shared Risk Group on the date of service.

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3. The Designated Provider was eligible to receive the Directed Payment.
4. The Qualifying Services were rendered by a Designated Provider on an eligible date of service.

C. For Qualifying Services rendered to Shared Risk Group Members, only GEMT Services are eligible for Directed Payments pursuant to this Policy. Such eligibility is subject to change based on whether CalOptima is financially responsible under the Shared Risk Group contract DOFR.

D. CalOptima shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy, including Attachment A and, as applicable, Attachment B of this Policy:

1. An Add-On Payment for Physician Services, Developmental Screening Services, Family Planning Services, and Value-Based Payment (VBP) Program Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

E. CalOptima shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and procedure codes, as well as the encounter data reported to DHCS, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services. For VBP Program Services, CalOptima shall further ensure that the VBP measures and ICD-10 Codes reported are appropriate for the services being provided.

F. CalOptima shall submit encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Section III.D. of this Policy.

G. CalOptima Provider Relations Department shall communicate the requirements of this Policy for Directed Payments, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service.

2. How Directed Payments will be processed.

3. Identify the payer of Directed Payments (i.e., CalOptima is financially responsible for specified Directed Payments for Qualifying Services provided to a CalOptima Direct Member and GEMT Services provided to a Shared Risk Group Member).

4. For CalOptima Direct, how to file a grievance and second level appeal with CalOptima. For a Shared Risk Group, a grievance must be filed with the Shared Risk Group before a second level appeal may be filed with CalOptima.

H. CalOptima Provider Relations Department is the point of contact for provider questions and technical assistance for Directed Payments.

I. A Designated Provider may file a complaint related to the processing or non-payment of a Directed Payment from CalOptima, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint and/or 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, as applicable.

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III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. –Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), cost-based reimbursement clinics, American Indian Health Services Programs, and Indian Health Care Providers (IHCP) including: Indian Health Services Memorandum of Agreement (IHS-MOA) clinics, FQHCs, Tribal FQHCs, and Community clinics, are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, CalOptima shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday (twelve (12) months);

         2) After the first birthday and before or on the second birthday (twenty-four (24) months); or

         3) After the second birthday and on or before the third birthday (thirty-six (36) months).

      ii. Developmental Screening Services provided when Medically Necessary, in addition to routine screenings, subject to the following conditions:

         1) Routine screenings conducted after the third birthday (thirty-six months) are not eligible for an Add-On Payment.

         2) Additional screening, with a showing of Medical Necessity based on risk identified through prior, timely developmental screenings, are eligible for an Add-On Payment up until the fourth birthday (48 months).

   b. Development Screening Services are not subject to any Prior Authorization requirements.

   c. Eligible Contracted Providers identified in Section III.A.2 of this Policy shall document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

   d. Eligible Contracted Providers identified in Section III.A.2. of this Policy shall document the following information in the Eligible Member's medical records:

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i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. Eligible Contracted Providers shall make the information set forth in Section III.A.2.d. of this Policy available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of this Policy conflicts with the applicable requirements of DHCS guidance, CMS-Approved Preprint, regulations, and/or statutes, such requirements shall control.

3. Family Planning Services: For dates of service on or after July 1, 2019, CalOptima shall make an Add-On Payment, in the amount and for the applicable procedure code as specified in Attachment A of this Policy, to Eligible Contracted Providers and non-contracted Providers, as applicable, that are Family Planning Providers rendering Family Planning Services to an Eligible Member.

a. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Family Planning Services.

b. Family Planning Services are not subject to any Prior Authorization requirements.

4. VBP Program Services: For dates of services on or after July 1, 2019, CalOptima shall make an Add-On Payment in the amount and for the applicable procedure code tied to the domain and measure as specified in Attachments A and B of this Policy, to Eligible Contracted Providers rendering VBP Program Services to Eligible Members at-risk or non-at-risk as described in Section III.A.4.c. of this Policy.

a. An Add-On Payment for VBP Program Services shall only be made to rendering Eligible Contracted Providers that:

i. Possess an individual (Type 1) National Provider Identifier (NPI); and

ii. Are practicing within their practice scope.

b. FQHCs, RHCs, American Indian Health Services Programs, Tribal Federally Qualified Health Care Centers (Tribal FQHC) and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for VBP Program Services.

c. When VBP Program Services are rendered to Eligible Members diagnosed with a substance use disorder, a serious mental illness, or who are homeless or have inadequate housing, CalOptima shall make Add-On Payment amounts corresponding to at-risk Eligible Members as specified in Attachment A of this Policy. When VBP Program Services are rendered to all other Eligible Members, CalOptima shall make Add-On Payment amounts corresponding to non-at-risk Eligible Members as specified in Attachment A of this Policy.

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d. CalOptima's Quality Analytics Department shall develop a monthly report to process payments which will include, at minimum, a list of:

i. Eligible Contracted Providers that satisfy the requirements of this Section III.A.4 of the Policy;

ii. Qualifying VBP Program Services in accordance with the technical specifications set forth in Attachment B of this Policy; and

iii. Add-On Payment amount(s).

5. ACEs Screening Services: For dates of service on or after January 1, 2020, CalOptima shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs Screening Services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. CalOptima shall only reimburse the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. Eligible Contracted Providers shall document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

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d. Eligible Contracted Providers shall make the information set forth in Section III.A.3.c. of this Policy available to CalOptima and/or DHCS upon request.

6. Abortion Services: For dates of service on or after July 1, 2017, CalOptima shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

   a. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

7. GEMT Services: For dates of service on or after July 1, 2018, CalOptima shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

   a. CalOptima shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

   b. In instances where a Member is found to have other sources of health coverage, CalOptima shall take appropriate action for cost avoidance or post-payment recovery, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by CalOptima with specified dates of service (i.e., between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), CalOptima shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, CalOptima shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by CalOptima no later than one (1) year from the date of service.

   a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by CalOptima to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.3. of this Policy.

   b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (i.e., between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to CalOptima and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, CalOptima shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

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2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, CalOptima shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.
   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Extension of Directed Payment Program: If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima shall:

   1. Reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as DHCS issues the final guidance.

   2. Ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

4. GEMT Services: CalOptima is not required to pay a Minimum Fee Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

   a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

      i. The Member has other sources of health coverage;

      ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

      iii. Incorrect or incomplete information about the subject claim or encounter was furnished by CalOptima to the GEMT Provider; or

      iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Overpayment

1. In the event CalOptima identifies that Directed Payments were made to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Provider, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative

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Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group.

D. Data Reporting

1. CalOptima shall reconcile Directed Payment data, including those received from the Health Networks pursuant to CalOptima Policy FF.2011: Directed Payments, and submit a report to DHCS within forty-five (45) days of the end of each applicable reporting quarter as required by DHCS, including an attestation confirming the completion of the report. Reports shall include CalOptima's Health Care Plan Code, as well as CPT, HCPCS, or procedure code, service month and year, program-specific measures, payer (e.g., CalOptima or the specific Health Network, as applicable), rendering Designated Provider's National Provider Identifier, and additional data if required by DHCS.

   a. CalOptima shall ensure updated quarterly reports are a replacement of all prior submissions. If no updated information is available for the quarterly report, CalOptima must submit an attestation to DHCS stating that no updated information is available.

   b. If updated information is available for the quarterly report, CalOptima must submit the updated quarterly report in the appropriate file format and include an attestation that CalOptima considers the report complete.

2. CalOptima shall continue to submit encounter data for the Directed Payments as required by DHCS.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes (Revised TBD)
B. VBP Program Specifications: Value-Based Payment Program Performance Measures 2020

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
C. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.1004: Payments for Hospitals Contracted to Serve a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group
E. 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
F. CalOptima Policy FF.2003: Coordination of Benefits
G. CalOptima Policy FF.2011: Directed Payments
H. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
I. CalOptima Policy GG.1116: Pediatric Preventive Services
J. CalOptima Policy HH.1101: CalOptima Provider Complaint
K. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
L. Title 22 of the California Code of Regulations, §§51002, 55000 and 55140(a)
M. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
N. State Plan Amendment (SPA) 21-0017: One-Year Reimbursement Rate Add-on for Eligible Ground Emergency Medical Transport Services

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O. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-013: Proposition 56 Directed Payments for Family Planning Services
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-014: Proposition 56 Value-Based Payment Program Directed Payments
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
Z. Proposition 56 Value-Based Payment Program Measure Valuation Summary

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of CalOptima Board of Directors
12/03/2020	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/04/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	12/03/2020	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal
Revised	TBD	FF.2012	Directed Payments for Qualifying Services Rendered to CalOptima Direct Members or to Shared Risk Group Members When CalOptima is Financially Responsible for the Qualifying Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Abortion Services	For purposes of this policy, these are specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
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.
Centers for Medicare & Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
Centers for Medicare & Medicaid Services (CMS) Approved Preprint	For purposes of this Policy, a preprint submission by DHCS pursuant to 42 CFR Section 438.6(c) for certain Directed Payment arrangement for specified time period that is approved by the Centers for Medicare & Medicaid Services (CMS). CMS-Approved Preprints are available on DHCS Directed Payments Program website upon CMS approval.

For 20220505 BOD Review Only

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 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.
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.
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable State fiscal years or calendar years: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services. 5.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.

For 20220505 POD Review Only

Term	Definition
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Eligible Contracted Provider	An individual rendering Provider who is contracted with CalOptima to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to CalOptima Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Family Planning Provider	A Provider who is licensed to furnish Family Planning Services within their scope of practice, is an enrolled Medi-Cal Provider, and is willing to furnish Family Planning Services to an Eligible Member.
Family Planning Services	For purposes of this Policy, specified family planning services, as listed by the procedure codes for the applicable period as specified in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
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)).
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

For 20220502 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	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to CalOptima Direct at the time Qualifying Services are rendered or assigned to a Shared Risk Group at the time GEMT Services are provided.
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Pending State Plan Amendment (SPA)	A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.
Physician Services	For purposes of this Policy, specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Prior Authorization	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.
Provider	For purpose of this Policy, an individual or entity that furnishes Medi-Cal Covered Services to Members and is licensed or certified to do so.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, Family Planning Services, VBP Program Services and GEMT Services.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.

For 20220505 BOD Review Only

Term	Definition
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Value-Based Payment (VBP) Program Services	Specified VBP program services, as defined in Attachments A and B of this Policy by the procedure and diagnosis codes tied to performance measures in the four domains (prenatal and postpartum care, early childhood, chronic disease management, and behavioral health integration) for the applicable period, that are Covered Services provided to an Eligible Member.

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For 20220505 BOD Review Only

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

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[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code[5]	Description	Minimum Fee Payment[5][6]
59840	Induced abortion, by dilation and curettage	$400.00
~~59840~~	~~Induced abortion, by dilation and curettage~~	~~$400.00~~
~~59841~~	~~Induced abortion, by dilation and evacuation~~	~~$700.00~~
59841	Induced abortion, by dilation and evacuation	$700.00

[5] ~~*Payment obligations for rates of at least $400 and $700 for eligible service codes*~~ *Inclusive of both K and O Procedure Types*

[6] *Payment obligations for rates of at least $400 and $700 for eligible service codes*

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Sources**: State Plan Amendment (SPA) 20-0009; ~~State Plan Amendment~~SPA ~~19-0020~~ 21-0017; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – ~~June 30, 20210~~ June 30, 2022

CPT Code	Description	Minimum Fee Payment[76]			
		SFY 18-19	SFY 19-2~~10~~0	SFY 20-21	SFY 21-22
A0429	Basic Life Support, Emergency	$339.00	$339.00	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00	$339.00	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72	$400.72	$400.72

[76] *Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

For 20220505 BOD Review Only

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2020

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/20
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[2]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[2]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Family Planning Services

1) **Program**: Proposition 56 Family Planning Services
2) **Source**: DHCS APL 20-013: Proposition 56 Directed Payments for Family Planning Services
3) **Dates of Service (DOS)**: On or after July 1, 2019

Procedure Code[1]	Description	Add-On Payment
J7296	Levonorgestrel-Releasing IU Coc Sys 19.5 mg	$2,727.00
J7297	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,053.00
J7298	Levonorgestrel-Rls Intrauterine Coc Sys 52 mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel-Rls Intrauterine COC Sys 13.5 mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo-Provera	$340.00
J7303	Contraceptive Vaginal Ring	$301.00
J7304	Contraceptive Patch	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 mg (2) & 1.5 mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00
81025	Urine Pregnancy Test	$6.00
55250	Removal of Sperm Duct(s)	$521.00
58340	Catheter for Hysterography	$371.00
58555	Hysteroscopy DX Sep Proc	$322.00
58565	Hysteroscopy Sterilization	$1,476.00
58600	Division of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(s)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal of Fallopian Tube	$1,216.00

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[1] *Services billed for the following CPT codes with modifiers UA or UB are excluded from these Add-On Payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Value-Based Payment (VBP) Program Services

1) **Program**: Proposition 56 Value-Based Payment (VBP) Program Services
2) **Source**: DHCS APL 20-014: Proposition 56 Value-Based Payment Program Directed Payments and VBP Program Specifications: Value-Based Payment Program Performance Measures 2020
3) **Dates of Service (DOS)**: On or after July 1, 2019

Domain	Measure	Add-On Payment for Non-At-Risk Eligible Members	Add-On Payment for At-Risk Eligible Members[3]
Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
Prenatal/Postpartum Care Bundle	Prenatal Care Visit	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Care Visits	$70.00	$105.00
Prenatal/Postpartum Care Bundle	Postpartum Birth Control	$25.00	$37.50
Early Childhood Bundle	Well Child Visits in First 15 Months of Life	$70.00	$105.00
Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	$70.00	$105.00
Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	$25.00	$37.50
Early Childhood Bundle	Blood Lead Screening	$25.00	$37.50
Early Childhood Bundle	Dental Fluoride Varnish	$25.00	$37.50
Chronic Disease Management Bundle	Controlling High Blood Pressure	$40.00	$60.00
Chronic Disease Management Bundle	Diabetes Care	$80.00	$120.00
Chronic Disease Management Bundle	Control of Persistent Asthma	$40.00	$60.00
Chronic Disease Management Bundle	Tobacco Use Screening	$25.00	$37.50
Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
Behavioral Health Integration Bundle	Screening for Clinical Depression	$50.00	$75.00
Behavioral Health Integration Bundle	Management of Depression Medication	$40.00	$60.00
Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	$50.00	$75.00

[3]At-Risk denotes Eligible Members diagnosed with serious mental illness, substance use disorder, or who are homeless or have inadequate housing. Non-At-Risk denotes all other Eligible Members.

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[4]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[4]Payment obligations for rates of at least $29 for eligible service codes

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code[5]	Description	Minimum Fee Payment[6]
59840	Induced abortion, by dilation and curettage	$400.00
59841	Induced abortion, by dilation and evacuation	$700.00

[5]*Inclusive of both K and O Procedure Types*

[6]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Sources**: State Plan Amendment (SPA) 20-0009; SPA 21-0017; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2022

CPT Code	Description	Minimum Fee Payment[7]			
		SFY 18-19	SFY 19-20	SFY 20-21	SFY 21-22
A0429	Basic Life Support, Emergency	$339.00	$339.00	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00	$339.00	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72	$400.72	$400.72

[7]*Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes*

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Note: This communication is for reference only and is subject to future changes as directed by DHCS.

The Department of Health Care Services (DHCS) is providing the measure specifications for the Value-Based Payment (VBP) Program measures. DHCS may make technical updates to VBP measure specifications as needed and appropriate to reflect recommended clinical practice, current coding standards, and/or changes in Centers for Medicare and Medicaid (CMS) Core Set measure specifications.

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Prenatal/Postpartum Care

Prenatal Pertussis ('Whooping Cough') Vaccine

Incentive payment to the provider for the administration of the pertussis vaccination to women who are pregnant

- Payment to rendering or prescribing provider for Tdap vaccine (CPT 90715) with an ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) anytime in the measurement year
- Payment may only occur once per delivery per patient
- Multiple births: Women who had two separate deliveries (different dates of service) between January 1 through December 31 of the measurement year may count twice

This measure supports the Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Immunization Status measure. The measure looks at the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

Prenatal Care Visit

Incentive payment to the provider for ensuring that the woman comes in for her initial prenatal visit

- Payment to rendering provider for provision of prenatal and preventive care on a routine, outpatient basis - not intended for emergent events
- No more than one payment per pregnancy per plan
- Payment for the first visit in a plan that is for pregnancy at any time during the pregnancy
- Prenatal visit is identified for this purpose by the use of the ICD-10 code for pregnancy supervision ('O09' or 'Z34' series) with a 992xx CPT code on the encounter

DHCS understands that women may change providers and plans during a pregnancy. Therefore, the first visit that occurs in a specific plan will be paid. The intent is to encourage that visit to happen quickly to begin the prenatal relationship.

This measure supports the Centers for Medicare and Medicaid (CMS) Child Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH). The Measure PPC-CH measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/Children's Health Insurance Program (CHIP).

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Postpartum Care Visits

Incentive payment for completion of recommended postpartum care visits after a woman gives birth

- Payment to rendering provider for provision of an Early Postpartum Visit (a postpartum visit on or between 1 and 21 days after delivery)
- Payment to rendering provider for provision of a Late Postpartum Visit (a postpartum visit on or between 22 and 84 days after delivery)
- Payment to the first visit in the time period (Early or Late)
- No more than one payment per time period (Early or Late)
- Postnatal visit is identified for this purpose by the use of the ICD-10 code for postpartum visit (Z39.2) on the encounter

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

Definitions

Early Postpartum Visit	A postpartum visit on or between 1 and 21 days after delivery
Late Postpartum Visit	A postpartum visit on or between 22 and 84 days after delivery

Incentive payments support the current American College of Obstetricians and Gynecologists recommendations regarding the two postpartum visits. DHCS expects that nationally utilized quality metrics will eventually align with the current clinical recommendations. The current CMS Adult Core Set Prenatal and Postpartum Care: Postpartum Care (PPC-AD) measure is expected to align with this in the future. The current Measure PPC-AD measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Postpartum Birth Control

Incentive payment to provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery

- Payment to rendering or prescribing provider for provision of most effective method, moderately effective method, or long-acting reversible method of contraception within 60 days of delivery
- Payment to the first occurrence of contraception in the time period
- No more than one payment per delivery

Delivery date is required for this measure to determine the timing of the postpartum visit. This payment is not specific to live births.

The codes used to calculate this measure are available in Tables CCP-C through CCPD at:

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https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-ofcare%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

This measure supports CMS Child and Adult Core Set Measures Contraceptive Care - Postpartum Measures (CCP-CH) (ages 15-20) and (CCP-AD) (ages 21-44) The Measure CCP measures among women who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Early Childhood

Well Child Visits in First 15 Months of Life

Separate incentive payment to a provider for each of the last three well child visits out of eight total - 6th, 7th and 8th visits. (Eight visits are recommended between birth and 15 months)

- Separate payment to each rendering provider for successfully completing each of the three well child visits at the following times:
  - 6 month visit – the first well care visit between 172 and 263 days of life
  - 9 month visit – the first well care visit between 264 and 355 days of life
  - 12 month visit – the first well care visit between 356 and 447 days of life
- Three payments per child are eligible for payment • Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439
  - ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the First 15 Months of Life (W15-CH). The Measure W15-CH measures the percentage of children who turned 15 months old during the measurement year and who had six or more wellchild visits with a primary care practitioner during their first 15 months of life.

Well Child Visits in 3rd – 6th Years of Life

Separate payment to each rendering provider for successfully completing each of the annual well child visits at age 3, 4, 5, and 6

- Payment for the first well child visit in each year age group (3, 4, 5, or 6 year olds)
- Any of the following meet the well care visit definition:
  - CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, G0438, G0439

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- ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

This measure supports CMS Child Core Set Measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH). The Measure W34-CH measures the percentage of children ages three to six who had one or more well-child visits with a primary care practitioner during measurement year.

All Childhood Vaccines for Two Year Olds

For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given on or before the second birthday

- Payment to each rendering provider for each final vaccine administered in a series to children turning age two in the measurement year:
  - Diphtheria, tetanus, pertussis (DTaP) – 4th vaccine
  - Inactivated Polio Vaccine (IPV) – 3rd vaccine
  - Hepatitis B – 3rd vaccine
  - Haemophilus Influenzae Type b (Hib) – 3rd vaccine
  - Pneumococcal conjugate – 4th vaccine
  - Rotavirus – 2nd or 3rd vaccine
  - Flu – 2nd vaccine
- A given provider may receive up to seven payments per year per patient
- A two year look back is required for each patient to capture the series of vaccines and identify the last vaccine in the series

This measure supports the CMS Child Core Set Childhood Immunization Status (CISCH). The Measure CIS-CH measures the percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Blood Lead Screening

Incentive payment to a provider for completing a blood lead screening in children up to two years of age

- Payment to each rendering provider for each occurrence of CPT code 83655 on or before the second birthday
- Provider can receive more than one payment

Blood lead tests will not be excluded if a child is diagnosed with lead toxicity.

This measure supports the HEDIS measure Lead Screening in Children (LSC). The LSC measure assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

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Dental Fluoride Varnish

Incentive payment to provider if provides oral fluoride varnish application for children 6 months through 5 years

- Payment to each rendering provider for each occurrence of dental fluoride varnish (CPT 99188 or CDT D1206) for children less than age six
- Payment for the first four visits in a 12 month period

Chronic Disease Management

Controlling High Blood Pressure

Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years old being seen by the provider for their diagnosis of high blood pressure

- Payment to each rendering provider for a non-emergent outpatient visit, or remote monitoring event, that documents controlled blood pressure
- A visit for controlled blood pressure must include a code for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension on the same day • Ages 18 to 85 at the time of the visit

Codes for controlled systolic, a code for controlled diastolic, and a diagnosis of hypertension are:

- Controlled Systolic:
  - CPT 3074F (systolic blood pressure less than 130) – CPT 3075F (systolic blood pressure less than 130-39)
- Controlled Diastolic:
  - CPT 3078F (diastolic blood pressure less than 80) – CPT 3079F (diastolic blood pressure less than 80-89)
- Hypertension:
  - ICD-10: I10 (essential hypertension)

This measure supports CMS Adult Core Set Controlling High Blood Pressure (CBP-AD). The measure CBP-AD measures the percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Diabetes Care

Incentive payment to provider for each event of diabetes (Hemoglobin A1c (HbA1c)) testing that shows the results of the test for members 18 to 75 years of age

- Payment to each rendering provider for each event of diabetes (HbA1c) testing (laboratory or point of care testing) that shows the results for members 18 to 75 years as coded with:
  - CPT 3044F most recent HbA1c < 7.0%
  - CPT 3045F most recent HbA1c 7.0-9.0% (through September 30, 2019)
  - CPT 3051F most recent HbA1c >= 7.0% and < 8.0% (as of October 1, 2019)

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  - CPT 3052F most recent HbA1c 8.0-9.0% (as of October 1, 2019)
  - CPT 3046F most recent HbA1c > 9.0%
- No more than four payments per year.
- Dates for HbA1c results must be at least 60 days apart.
- Diabetes diagnosis is not required to allow for screening of individuals at increased risk of diabetes.

This measure supports both CMS Adult Core Set measures HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD) The measure HA1C-AD assesses the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test, and the measure HPC-AD measures the percentage with an HbA1c level <9.0%.

Control of Persistent Asthma

Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of asthma who has prescribed controller medications

- Payment to each prescribing provider that provided controller asthma medications during the year for patients who had a diagnosis of asthma, based on the Asthma Value Set, in the measurement year or the year prior to the measurement year
- Each provider is paid once per year per patient
- Ages 5 to 64 at the time of the visit

The Asthma Value Set includes the following diagnosis codes:

J45.20 Mild intermittent asthma, uncomplicated
J45.21 Mild intermittent asthma with (acute) exacerbation
J45.22 Mild intermittent asthma with status asthmaticus
J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
J45.40 Moderate persistent asthma, uncomplicated
J45.41 Moderate persistent asthma with (acute) exacerbation
J45.42 Moderate persistent asthma with status asthmaticus
J45.50 Severe persistent asthma, uncomplicated
J45.51 Severe persistent asthma with (acute) exacerbation
J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus J45.909 Unspecified asthma, uncomplicated
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

This measure specification supports CMS Child and Adult Core Set measures Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD). These measures assess the percentage of beneficiaries ages 5-64 who were identified as having

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persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater.

Tobacco Use Screening

Incentive payment to provider for tobacco use screening or counseling provided to members 12 years and older

- Payment to rendering provider for any of the following CPT codes: 99406, 99407, 4004F, or 1036F (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco.

This measure aligns with U.S. Preventive Services Task Force (USPFTF) recommendations with regards to screening/counseling for tobacco

- Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Adolescents: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions

Adult Influenza ('Flu') Vaccine

Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older

- Payment to rendering or prescribing provider for up to two flu shots given throughout the year for patients 19 and older at the time of the flu shot
- No more than one payment per patient per quarter for the first quarter of the year (January through March) or the last quarter of the year (October through December)
- If more than one provider gives the shot in the quarter only the first provider gets paid in that quarter

This measures supports the American Medical Association Physician Consortium for Performance Improvement (AMA-PCPI) NQF 0041 Preventive Care and Screening: Influenza Immunization which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization.

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Screening for Clinical Depression

Incentive payment to provider for conducting screening for clinical depression (using a standardized screening tool) for beneficiaries 12 years and older

- Payment to rendering provider for any of the following CPT codes for screening for clinical depression: G8431 or G8510 (equivalent payment for all codes)
- No more than one payment per provider per patient per year
- Must be an outpatient visit

This measure supports CMS Core Set measure Screening for Depression and Followup Plan: Age 18 and Older (CDF-AD). The measure CDF-AD assesses the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Management of Depression Medication

Incentive payment to provider for beneficiaries 18 years and older with a diagnosis of major depression and newly treated with an anti-depressant medication who has remained on the anti-depressant medication for at least 12 weeks

- Payment to prescribing providers for the Effective Acute Phase Treatment for patients 18 years and older with a diagnosis of major depression 60 days before the new prescription through 60 days after
- Effective Acute Phase Treatment is at least 84 days during 12 weeks of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days)
- Payment to each prescribing provider that prescribed antidepressant medications during Effective Acute Phase Treatment period
- No more than one Effective Acute Phase Treatment per year

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	At least 84 days of treatment beginning on the IPSD through 114 days after the IPSD.
Major depression diagnosis codes	ICD10: F32.0,F32.1,F32.2,F32.3,F32.4,F32.9,F33.0, F33.1,F33.2,F33.3,F33.41,F33.9

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Antidepressant medication	NCQA's Medication List Directory (MLD) of NDC codes for Antidepressant Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndclicense/hedis-2019-final-ndc-lists/.

This measure supports the CMS Adult Core Set measure Antidepressant Medication Management (AMM-AD). The Measure AMM-AD Effective Acute Phase Treatment measures the percentage of beneficiaries age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication for at least 84 days (12 weeks).

Screening for Unhealthy Alcohol Use

Incentive payment to provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older

- Payment to rendering provider for any of the following CPT codes: 99408, 99409, G0396, G0397, G0442, G0443, H0049, or H0050 (equivalent payment for all codes)
- No more than one payment per provider per patient per year

This measure specification supports Quality Identifier #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. The Measure NQF 2152 measures the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.

The measures aligns with USPFTF Recommendations with regards to alcohol screening tools:

- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioralcounseling-interventions

Overarching Payment Conditions

Data to be used to calculate payments:

- Medi-Cal administrative data reported through the Managed Care Plans encounter data
- Medi-Cal administrative data reported in the Medi-Cal Eligibility Data System
- For measures involving immunizations, the expectation is that immunizations reported through the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 will be used as a supplementary data source
- For the Blood Lead Screening measure, the expectation is that blood lead test results reported through the CDPH Blood Lead Registry may be used as a supplementary data source

Providers will be identified based on:

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- National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1)
- If the rendering or ordering is not filled, then look for prescribing provider field that is an NPI for an individual (Type 1)
- If the rendering, ordering, or prescribing is not filled, then look for billing provider that is an NPI for an individual (Type 1)
- To qualify for payment, providers must be practicing within their practice scope and must have an individual (Type 1) NPI. For example, if a pharmacist (not the pharmacy) provides an immunization, then that pharmacist could receive payment.

Beneficiary inclusion criteria:

- Services for beneficiaries with Medicare Part B will be excluded
- Payments are based on Medi-Cal having the encounter data

Beneficiary exclusion criteria:

- Encounters occurring at Federally Qualified Health Centers (FQHCs), Rural Health Clinics, American Indian Health Clinics, and Cost Based Reimbursement Clinics will be excluded from payment

An enhanced payment factor will be applied to the above services provided to beneficiaries with the following conditions:

- Substance Use Disorder (SUD) – CMS Core Set Measure Set: AOD Abuse and Dependence Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Serious Mental Illness (SMI) – CMS Core Set Measure Sets: Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set, and Major Depression Value Set https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fqualityof-care%2Fdownloads%2F2019-adult-value-set-directory.zip
- Homeless ICD-10 Diagnosis code with the following values:
  - Z59.0 Homeless
  - Z59.1 Inadequate Housing

The SUD and SMI at-risk population will be determined by the presence of an at-risk diagnosis in the health plan encounter data during the measurement year. The diagnosis of homeless should be on the encounter data for the VBP eligible service.

Post utilization monitoring will be performed to ensure overuse of services is not occurring.

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Technical Updates to the Specifications

Updated in May 7, 2020 Version:

- Removed from the Diabetes measure the reference to the Hemoglobin A1c (HA1C-AD) Testing measure, which was removed from the CMS Adult Core Set in the 2020 reporting year (data collection year 2019).
- Adjusted the Diabetes measure to indicate CPT 3045F is valid through September 30, 2019 and is replaced with CPT 3051F and CPT 3052F as of October 1, 2019.
- Removed from the Tobacco Use Screening measure codes CPT G0436 and CPT G0437, which were retired September 30, 2016.
- Added to the Screening for Unhealthy Alcohol Use measure codes CPT G0442 and CPT G0443.

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Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a Health Network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted Provider.

B. A Provider shall submit a claim for Covered Services rendered on, or after, January 1, 2010, as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the contracted Provider agreement. If the contracted Provider agreement does not specify a time frame, the contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services - Emergency medical services *do not* require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a Health Network must pay the emergency triage fee and request Medical Records;

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3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima policies to be services the Member was entitled to have furnished, or paid for, by CalOptima or a Health Network; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

   a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider Agreement.

2. Non-Contracted Providers

   a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

   b. CalOptima or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

   c. If CalOptima or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

   d. CalOptima or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

   e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

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i. CalOptima or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a clean claim regardless of the dates of service.

E. If CalOptima or a Health Network denies payment of a Clean Claim, CalOptima or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the Member of his or her right to request an Appeal;

c. Describe the Appeals process, time frames, and other elements; and

d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, but is covered by and payable under a Member's Medi-Cal coverage, CalOptima or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Appeal and Grievance

1. A Provider may Appeal a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. ~~A~~In case of a Payment Dispute Resolutions (PDR), the CalOptima Claim Administration Department or Health Network shall inform the Non-Contracted Provider ~~may file a Grievance~~ in the notice of PDR decision of his right to file a complaint with CalOptima, in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

3. The CalOptima Claims Administration Department and Health Network staff shall accept, track, report all NCP PDRs as determined by CalOptima's Audit & Oversight Department.

4. Non-Contracted Providers may file a PDR within one hundred and eighty (180) calendar

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days from the receipt of the Remittance Advice (RA) for level of payment disputes (The notice of initial determination is presumed to be received five (5) calendar days from the date of the RA unless there is evidence to the contrary.).

5. The Claims Administration Department or the Health Network shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request.

6. The CalOptima Grievance and Appeals Resolution Service and Claims Administration Departments and Health Networks shall document all actions taken related to the PDR, or Appeal, request in its tracking system and/or hard copy including, but not limited to:

a. Provider's name;

b. Date received;

c. Name of staff that received the complaint at CalOptima;

d. Designated contact person;

e. Description of the complaint;

f. Date;

g. Dispositions; and

h. Appeal Review.

III. PROCEDURE

A. If CalOptima or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) business days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) business days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a Health Network notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

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1. If CalOptima or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) business days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

   a. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a Health Network shall send a second (2nd) letter to the contracted/Non-Contracted Provider requesting such information.

   b. If CalOptima or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a Provider Grievance, in accordance with Section II.I. of this Policy.

6. If CalOptima or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a Grievance in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima or a Health Network Reopening of Claims

1. CalOptima or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

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d. Misapplication of a fee schedule;

e. Computer errors;

f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

a. Failing to bill for certain items or services;

b. Untimely filing; or

c. Redetermination requests.

3. CalOptima or a Health Network, a Provider, or any other party to the determination decision may request CalOptima or a Health Network reopen a claim as follows:

a. The request may be made verbally or in writing.

b. CalOptima or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima or a Health Network shall issue a revised electronic or paper remittance advice notice.

d. If the reopening action results in an adverse revised claim determination or decision, CalOptima or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide Appeal rights.

4. When reviewing a request to reopen a claim, CalOptima or a Health Network can consider new and material evidence if it meets the following:

a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

b. Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and

c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

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7. The decision of CalOptima or a Health Network to reopen a claim determination is not an initial claim determination and is therefore not subject to Appeal.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any appeal rights.

G. Record Maintenance

1. CalOptima or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NCMCP; OMB Approval 0938-0829 (Expires: 02/28/2023)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the

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Department of Health Care Services (DHCS) for Cal MediConnect

C. CalOptima PACE Program Agreement

D. CalOptima Policy CMC.3103: Claims Coordination of Benefits

~~E. CalOptima Policy CMC.9003: Standard Appeal~~

~~F. CalOptima Policy CMC.9004: Expedited Appeal~~

~~G.~~E. ~~CalOptima Policy CMC.~~9005: Payment Appeal

~~H.~~F. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts

~~I.~~G. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical

~~J.~~H. CalOptima Policy MA.3103: Coordination of Benefits

~~K. CalOptima Policy MA.9003: Standard Appeal~~

~~L. CalOptima Policy MA.9004: Expedited Appeal~~

~~M.~~I. ~~CalOptima Policy MA.~~9005: Payment Appeal

~~N.~~J. CalOptima Policy MA.9006: Provider Complaint Process

~~O.~~K. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File

~~P.~~L. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update

~~Q.~~M. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections

~~R.~~N. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

~~S.~~O. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions

~~T.~~P. Patient Protection and Affordable Care Act, §6404

~~U.~~Q. Title 31, United States Code (U.S.C.), §3902(a)

S. Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	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: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review. PACE: A Participant's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
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.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

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Term	Definition
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 Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima, or other services as authorized by the CalOptima Board of Directors.
Emergency Care	~~PACE:~~ Covered Services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Emergency Services	~~OneCare/OneCare Connect:~~ Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	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." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
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.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.

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Term	Definition
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
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	A beneficiary enrolled in a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a Participant to receive a specific service or procedure.
Provider	OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

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Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima or a Health Network in accordance with applicable statutory, and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a contracted Provider.

B. A Provider shall submit a claim for Covered Services rendered on, or after, January 1, 2010, as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the contracted Provider agreement. If the contracted Provider agreement does not specify a time frame, the contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services - Emergency medical services *do not* require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima or a Health Network does not have a notification of an inpatient admission from the ER on file for the room and board charges, CalOptima or a Health Network must pay the emergency triage fee and request Medical Records;

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3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima policies to be services the Member was entitled to have furnished, or paid for, by CalOptima or a Health Network; and

7. CalOptima or a Health Network shall provide Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Policy EE.1141Δ: CalOptima Provider Contracts.

D. CalOptima or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, a claim from a contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider Agreement.

2. Non-Contracted Providers

a. CalOptima or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

b. CalOptima or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

c. If CalOptima or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

e. For Dates of Service effective beginning January 1, 2019, CalOptima or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. CalOptima or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a clean claim regardless of the dates of

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service.

E. If CalOptima or a Health Network denies payment of a Clean Claim, CalOptima or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

   a. The specific reasons for the payment denial;

   b. Inform the Member of his or her right to request an Appeal;

   c. Describe the Appeals process, time frames, and other elements; and

   d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program, but is covered by and payable under a Member's Medi-Cal coverage, CalOptima or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Appeal and Grievance

1. A Provider may Appeal a claim determination in accordance with CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

2. In case of a Payment Dispute Resolutions (PDR), the CalOptima Claim Administration Department or Health Network shall inform the Non-Contracted Provider in the notice of PDR decision of his right to file a complaint with CalOptima, in accordance with CalOptima Policy MA.9006: Provider Complaint Process.

3. The CalOptima Claims Administration Department and Health Network staff shall accept, track, report all NCP PDRs as determined by CalOptima's Audit & Oversight Department.

4. Non-Contracted Providers may file a PDR within one hundred and eighty (180) calendar days from the receipt of the Remittance Advice (RA) for level of payment disputes (The notice of initial determination is presumed to be received five (5) calendar days from the date of the RA unless there is evidence to the contrary.).

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5. The Claims Administration Department or the Health Network shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request.

6. The CalOptima Grievance and Appeals Resolution Service and Claims Administration Departments and Health Networks shall document all actions taken related to the PDR, or Appeal, request in its tracking system and/or hard copy including, but not limited to:

   a. Provider's name;

   b. Date received;

   c. Name of staff that received the complaint at CalOptima;

   d. Designated contact person;

   e. Description of the complaint;

   f. Date;

   g. Dispositions; and

   h. Appeal Review.

III. PROCEDURE

A. If CalOptima or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) business days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) business days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima's notice, CalOptima's or a Health Network notice, CalOptima or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) business days after the date of receipt, in writing, with a request for the missing information. If CalOptima or a Health Network requests reasonably relevant information from a

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Provider in addition to information that the Provider submits with a claim, CalOptima or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

   a. If CalOptima or a Health Network does not receive the requested information within forty-five (45) calendar days after it receives the claim, CalOptima or a Health Network shall send a second (2nd) letter to the contracted/Non-Contracted Provider requesting such information.

   b. If CalOptima or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a Provider Grievance, in accordance with Section II.I. of this Policy.

6. If CalOptima or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a Grievance in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima or a Health Network Reopening of Claims

1. CalOptima or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

   d. Misapplication of a fee schedule;

   e. Computer errors;

   f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

   g. Incorrect data items, such as provider number, use of a modifier or date of service.

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2. The following does not constitute grounds for Reopening of a claim:

   a. Failing to bill for certain items or services;

   b. Untimely filing; or

   c. Redetermination requests.

3. CalOptima or a Health Network, a Provider, or any other party to the determination decision may request CalOptima or a Health Network reopen a claim as follows:

   a. The request may be made verbally or in writing.

   b. CalOptima or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

   c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima or a Health Network shall issue a revised electronic or paper remittance advice notice.

   d. If the reopening action results in an adverse revised claim determination or decision, CalOptima or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide Appeal rights.

4. When reviewing a request to reopen a claim, CalOptima or a Health Network can consider new and material evidence if it meets the following:

   a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

   b. Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and

   c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal.

7. The decision of CalOptima or a Health Network to reopen a claim determination is not an initial claim determination and is therefore not subject to Appeal.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima or a Health Network shall notify the requesting party in writing of the decision not to reopen.

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F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima or a Health Network shall ensure the following for written notifications:

   a. Are delivered to the last known address when the determination or decision is reopened and revised;

   b. State the rational and basis for the reopening and revision;

   c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

   d. Provide information on any appeal rights.

G. Record Maintenance

1. CalOptima or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare Integrated Denial Notice CMS 10003-NCMCP; OMB Approval 0938-0829 (Expires: 02/28/2023)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima PACE Program Agreement
D. CalOptima Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Policy CMC.9005: Payment Appeal
F. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
G. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
H. CalOptima Policy MA.3103: Coordination of Benefits
I. CalOptima Policy MA.9005: Payment Appeal
J. CalOptima Policy MA.9006: Provider Complaint Process
K. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
L. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update

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M. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
N. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
O. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
P. Patient Protection and Affordable Care Act, §6404
Q. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	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: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review. PACE: A Participant's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
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.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
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 Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima, or other services as authorized by the CalOptima Board of Directors.

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Term	Definition
Emergency Care	Covered Services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	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." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
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.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima or a Health Network.
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

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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	A beneficiary enrolled in a CalOptima program.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Prior Authorization	OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a Participant to receive a specific service or procedure.
Provider	OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

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Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Payment

Date:

Member number:

Claim number:

Name: **<Beneficiary's full name>**
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Your request was *denied*

We've *denied* the *payment of medical services/items or Part B drug or Medicaid drug* listed below requested by you or your doctor [*provider]*:

Why did we deny your request?

We *denied* the *payment of medical services/items or Part B drug or Medicaid drug* listed above because

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare (HMO SNP) to review our decision by asking us for an appeal**.** [If the action taken involves Medicaid benefits insert the following: Plan level appeal's process must be exhausted prior to requesting a State Hearing.]

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Plan Appeal: Ask OneCare for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with OneCare" for information on how to ask for a plan level appeal.

> ***How to keep your services while we review your case:*** *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your appeal, you may have to pay for these services.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: **1-877-412-2734** to learn how to name your representative. TTY users call <**1-800-735-2929**>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of appeals with OneCare

Standard Appeal – We'll give you a written decision on a standard appeal within ***30 days*** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item or Part B drug you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a *medical service/item or Part B drug* you've already received.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with OneCare

Step 1: You, your representative, or your doctor [*provider*] must ask us for an appeal. Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the *medical service/item or Part B drug or Medicaid drug*. Call your doctor if you need this information.

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If you're asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.
We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal. You can also call us .

For a Standard Appeal:

Mailing Address: OneCare
Attention: Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868
Phone: 1-877-412-2734 TTY Users Call: <1-800-735-2929>
Fax: 1-714-246-8562

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 1-877-412-2734 TTY Users Call: <1-800-735-2929>
Fax: 1-714-246-8562

What happens next?

If you ask for an appeal and we continue to deny your request for *payment of* a *medical service/item or Part B drug or Medicaid drug*, we'll automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

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How to ask for a Medicaid State Fair Hearing

If OneCare denies your appeal request, you can take the steps listed below to request a State Fair Hearing.

Step 1: *You or your representative must ask for a State Fair Hearing (in writing) within 120 days of the date of the notice that denies your appeal request. You have up to <180> days if you have a good reason for your request being late.*

Your {written} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: *Send your request to:*
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Phone: 1-800-952-5253 Fax: 1-916-651-5210 or 1-916-651-2789

[A copy of this notice has been sent to:]

Get help & more information

- OneCare Customer Service: Toll Free: 1-877-412-2734, TTY users call: <1-800-735-2929> 24 hours, 7 days a week or www.caloptima.org/onecare.
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.
- Medi-Cal Managed Care Ombudsman Office: 1-888-452-8609
- Office on Aging, OC Community Services: 1-800-510-2020

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OneCare (HMO SNP) is a Medicare Advantage organization with a Medicare Contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-412-2734** (TTY: <**1-800-735-2929**>).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-412-2734** (TTY: <**1-800-735-2929**>).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-412-2734** (TTY: <**1-800-735-2929**>).

{Enclosures: Notice of Non Discrimination: H5433_20MM012_C}

For 20220505 BOD Review Only

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed toward the end under "Get help & more information." You can also see Chapter 9 of the *Member Handbook* for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:

Claim number:

Name: <Beneficiary's full name>
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Your request was denied

We've denied, the payment of medical services/items *or* Part B drug *or* Medicaid drug listed below requested by you or your doctor *or* provider

Why did we deny your request?

We denied, the payment of medical services/items listed above because:

For 20220505 BOD Review Only

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare Connect to review our decision by asking us for a Level 1 Appeal (sometimes called an "internal appeal" or "plan appeal").

Level 1 Appeal with OneCare Connect: Ask OneCare Connect for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for a Level 1 Appeal with OneCare Connect" for information on how to ask for a plan level appeal.

> **How to keep your services while we review your case:** If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. **If you want the service to continue, you must ask for an appeal within 10 calendar days** of the date of this notice or before the service is stopped or reduced, whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: **<1-855-705-8823>** to learn how to name your representative. TTY users call **<711>**. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days**, after we get your appeal. Our decision might take longer if you ask for an extension or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item *or* Part B drug *or* Medicaid drug you've already received, we'll give you a written decision within **60 calendar days**.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within **30 calendar days**.

How to ask for a Level 1 Appeal with OneCare Connect

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing

We recommend keeping a copy of everything you send us for your records.

For 20220505 BOD Review Only

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Mailing Address:
OneCare Connect
Attention: Grievance and Appeals Resolution Services
<505 City Parkway West
Orange, CA 92868>

Phone: <1-855-705-8823> TTY Users Call: <711>
Fax: <1-714-246-8562>

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for payment of a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TTY: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

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The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

Get help & more information

- Call **OneCare Connect** at **<1-855-705-8823>**, 24 hours a day, 7 days a week. TTY users call <711>. You can also visit our website at www.caloptima.org/onecareconnect.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-800-333-4114.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the *Member Handbook*** for information about how to make an appeal.

OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **<1-855-705-8823>** (TTY **711**), 24 hours a day, 7 days a week. This call is free.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **<1-855-705-8823>** (TTY **711**), las 24 horas al día, los 7 días de la semana. Esta llamada es gratuita.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **<1-855-705-8823>** (TTY **711**). 一周7天，一天24小時。 此通電話免費。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **<1-855-705-8823>** (TTY **711**), 24 giờ một ngày, 7 ngày một tuần. Cuộc gọi này hoàn toàn miễn phí.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **<1-855-705-8823>** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo. Libre ang tawag na ito.

For 20220505 BOD Review Only

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 주 7 일, 하루 24 시간 운영되는 **<1-855-705-8823>** (TTY **711**) 번으로 전화해 주십시오. 통화는 무료입니다.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **<1-855-705-8823>** (TTY (հեռատիպ)՝ **711**):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. لطفاً طی 24 ساعت شبانه روز و 7 روز هفته باشماره **<1-855-705-8823>** (TTY **711**) تماس بگیرید. این تماس رایگان است.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **<1-855-705-8823>** (линия TTY **711**), 24 часа, 7 дней в неделю. Звонок бесплатный.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**<1-855-705-8823>** (TTY **711**)まで、お電話にてご連絡ください。24 時間年中無休のフリーダイヤルです。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على الرقم **<1-855-705-8823>** وعلى (TTY **711**)، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع. هذه المكالمة مجانية

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ **<1-855-705-8823>** (TTY **711**) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਕਾਲ ਮੁਫਤ ਹੈ।

Cambodian: សំខាន់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺមានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **<1-855-705-8823>** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ ការហៅទូរស័ព្ទនេះគឺឥតគិតថ្លៃ។

Hmong: LUS QHIA: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau **<1-855-705-8823>** (TTY **711**) 24 teev tuaj ib hnub, 7 hnub tuaj ib lub lim tiam. Hu tau tus xovtooj no dawb xwb.

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। दिन के 24 घंटे, सप्ताह के सातों दिन, **<1-855-705-8823>** (TTY **711**) पर कॉल करें। यह कॉल मुफ्त है।

Thai: โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรฟรี **<1-855-705-8823>** (TTY **711**) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์.

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣຟຣີ **<1-855-705-8823>** (TTY **711**), ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ມື້ຕ່ອອາທິດ.

You can get this document for free in other formats, such as large print, braille, or audio. Call **<1-855-705-8823>**, 24 hours a day, 7 days a week. TTY users call 711. The call is free.

(Enclosure: Full Notice of Non-Discrimination Insert: <H8016_22MM014>)

For 20220505 BOD Review Only

CalOptima PACE
13300 Garden Grove Blvd
Garden Grove, CA 92843
(714) 468-1100
TDD/TTY: (714) 468-1063

{Date}

{Participant's Name or Representative}
{C/o Participant's Name}
{Address}

RE: Notice of Action (NOA) for Service or Payment Request

Dear Mr/s {Name}:

Your request of [insert date] for [insert brief description of requested service or payment for service]

Has been: __**Denied** __**Deferred** __**Modified** for the reason(s) indicated below:

- ❑ Is not medically necessary
- ❑ Requested services will not improve or contribute to sustaining your health
- ❑ An alternative service is provided to meet your care needs
- ❑ Did not meet authorization criteria
- ❑ Is not a benefit of the PACE Program
- ❑ Requires additional information or consult
- ❑ Requested service has potentially negative health and safety issues
- ❑ Other (please describe):_____

This decision was based on the following criteria or clinical guidelines:

_____

_____

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached *"Information for Participants about the Appeals Process"* for your right to request further action. You may call your Social Worker or our Quality Assurance Department at (714) 468-1100 who will explain these processes to you. For the hearing impaired (TTY/TDD), please call (714) 468-1063.

Sincerely,

[First Initial and last name of Examiner
Claims Administration

For 20220505 BOD Review Only

INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at **CalOptima PACE** share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. **CalOptima PACE** will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained at all times throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When **CalOptima PACE** decides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your Member Enrollment Agreement Terms and Conditions) and annually after that. You will also receive this information and necessary appeals forms whenever **CalOptima PACE** denies, defers or modifies a request for a service or request for payment.

Definitions:
An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions or termination of services.

A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE employee or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If you

For 20220505 BOD Review Only

request and expedited appeal, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

*Note: For **CalOptima PACE** participants enrolled in Medi-Cal – **CalOptima PACE** will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and **CalOptima PACE** denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.
2. You can make your appeal either verbally(in person or by telephone) or in writing; ask any PACE Program staff of the center you attend to help you start the process. CalOptima PACE will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send to the address listed below. Otherwise you or your representative may submit this information in person. If more information is needed, you will be contacted by **the Quality Assurance Department** who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our **Quality Assurance Department** at **714-468-1100 or our toll-free number at (855) 785-2584** to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call **(714) 468-1063**.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Quality Assurance Department
   CalOptima PACE
   13300 Garden Grove Blvd
   Garden Grove, CA 92843

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a standard appeal. For and expedited appeal, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.

For 2025 BOD Review Only

6. The reconsideration of **CalOptima PACE** decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon **CalOptima PACE** completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, **CalOptima PACE** will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below:

The Decision on your Appeal:
If we decide fully in your favor on a **standard appeal** for a request for ***service***, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights,** below). We also are required to notify you as soon as we make a decision and also to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal** we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision and also to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

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The **Medicare program** contracts with an "Independent Review Organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if **CalOptima PACE** wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **Medicare Medi-Cal program or both,** we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

For 02220-5 BOD Review Only

Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: (800)-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: (800)-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from **CalOptima PACE**.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend, or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in **Orange County**, if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, **CalOptima PACE** will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is **not** in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor. The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14524-1302
Telephone: (585) 348-3300
Facsimile: (585) 425-5292

For 20220505 BOD Review Only

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

MICHELLE BAASS
DIRECTOR

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GOVERNOR

DATE: December 10, 2021

ALL PLAN LETTER 21-005 (REVISED)
SUPERSEDES ALL PLAN LETTER 18-023

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE WHOLE CHILD MODEL PROGRAM

SUBJECT: CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide direction and guidance to Medi-Cal managed care health plans (MCPs) participating in the California Children's Services (CCS) Whole Child Model (WCM) program. This APL conforms with CCS Numbered Letter (N.L.) 03-0421, which provides direction and guidance to county CCS programs on requirements pertaining to the WCM program.[1] This APL supersedes APL 18-023.[2] Revised text is found in *italics.*

BACKGROUND:
Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) authorized the Department of Health Care Services (DHCS) to establish the WCM program in designated County Organized Health System (COHS) or Regional Health Authority counties.[3] The purpose of the WCM program is to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members. MCPs operating in WCM counties integrate Medi-Cal managed care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.[4, 5]

[1] CCS N.L.s can be found at: https://www.dhcs.ca.gov/services/ccs/pages/ccsnl.aspx
[2] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[3] SB 586 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB586
[4] See Health and Safety Code (HSC) Section 123850(b)(1). HSC is searchable at: http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC
[5] See Welfare and Institutions Code (WIC) Section 14094.11. WIC is searchable at: https://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=WIC&tocTitle=+Welfare+and+Institutions+Code+-+WIC

MCPs authorize care that is consistent with CCS program standards and that is provided by CCS-paneled providers, *CCS*-approved Special Care Centers (SCCs), and approved pediatric acute care hospitals. The WCM program supports active participation by parents and families of CCS-eligible members and ensures that members receive protections such as continuity of care, oversight of network adequacy standards, quality performance of providers, and routine grievance and appeal processes.

WCM has been implemented in 21 COHS counties (see the following chart for more details).

MCP	COHS Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – Implemented January 1, 2019	
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – Implemented July 1, 2019	
CalOptima	Orange

POLICY:
Participating MCPs assume full financial responsibility, with some exceptions, of authorization and payment of CCS-eligible medical services including, but not limited to, service authorization activities, claims processing and payment, case management, and quality oversight. Service authorization activities include Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU) and referrals arising from Medical Therapy Conference, Medical Therapy Program (MTP), and Medical Therapy Unit (MTU) that are not otherwise the responsibility of the MTU.

Under the WCM, the MCP, county CCS program, and DHCS each bear responsibility for various administrative functions to support the CCS program. Responsibility for the CCS program's eligibility functions under the WCM is determined by whether the county CCS program operates as an independent or dependent county.[6] Independent CCS counties maintain responsibility for CCS program medical eligibility determinations for potential members, including responding to and tracking appeals relating to CCS program medical

[6] A link to the Division of Responsibility chart can be found on the CCS WCM page of the DHCS website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx

eligibility determinations and annual medical eligibility redeterminations. In dependent counties, DHCS maintains responsibility for CCS program medical eligibility determinations and redeterminations, while the county CCS programs maintain responsibility for financial and residential eligibility determinations and re-determinations. MCPs are responsible for providing all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed, for CCS-eligible members.

MCPs are responsible for identifying and referring potential CCS-eligible members to the county for CCS program eligibility determination. MCPs are also required to provide services to CCS-eligible members with other health coverage, with full scope Medi-Cal as the payor of last resort.

The implementation of WCM does not affect the activities and functions of the MTP. However, MCPs must refer members to local county CCS programs if members are suspected of having an MTP eligible condition. As a part of the CCS eligibility review, local county CCS programs will review and determine MTP eligibility, if applicable. WCM counties participating with the MTP receive a separate allocation for this program and are responsible for care coordination of MTP services. MTPs must submit referrals to MCPs for medically necessary specialty services and follow-up treatment, as prescribed by the MTU Conference Team Physician.

MCPs are required to use all current and applicable CCS program guidelines in the development of criteria for use by the MCP's chief medical officer or equivalent and other care management staff. CCS program guidelines include CCS program *statutes,* regulations, additional forthcoming regulations related to the WCM program, CCS N.L.s, and county CCS program information notices.[7, 8] Any N.L.s. that fall within the following Index Categories, as identified by DHCS, are applicable to WCM MCPs:[9]

Index Category
Authorizations/Benefits
Case Management
Pharmaceutical
Standards, Hospital/PICU/NICU

[7] CCS program statutes and regulations can be found at: https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx
[8] CCS program guides can be found at: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx
[9] The WCM CCS N.L. Category List is available under the Resources and Information heading on the CCS WCM page of the DHCS website

For these applicable N.L.s, the WCM MCP must assume the role of the county or state CCS program as described in the N.L. In addition to the requirements included in this APL, MCPs must comply with all *other* applicable *APLs,* state and federal laws and regulations, as well as all contractual requirements.

I. MCP AND COUNTY COORDINATION

MCPs and county CCS programs must coordinate the delivery of CCS services to CCS-eligible members according to the parameters outlined in the Memorandum of Understanding (MOU). They must also continually update policies, procedures, and protocols, as appropriate, and discuss activities related to the MOU and other WCM related matters as prescribed in the MOU.

A. Memorandum of Understanding

Participating MCPs and county CCS programs must execute an MOU that outlines their respective responsibilities and obligations under the WCM program. All MOUs must follow the MOU template.[10] The purpose of the MOU is to explain how the MCP and county CCS program coordinate care, conduct program management activities, and exchange information required for the effective and seamless delivery of services to WCM members. The MOU between the individual county and the MCP *must* ensur*e* collaboration between the MCP and county CCS program. The MOU is customizable based on the needs of the individual county CCS program and the MCP. The MOU must include, at a minimum, all of the provisions specified in the MOU template posted on the CCS WCM page of the DHCS website and must be consistent with the requirements of SB 586. MCPs must submit MOUs to DHCS for approval.

B. Transition Plan

To be approved to participate in the WCM program, MCPs must develop a comprehensive transition plan detailing their collaboration with the county CCS program on the transition of existing CCS members into managed care for treatment of their CCS-eligible conditions. The transition plan must describe the transfer of case management; care coordination; provider referrals; and service authorization, including administrative functions, from the county CCS program to the MCP.[11] The transition plan must also include communication with members regarding, but not limited to, authorizations, provider network, case management, and ensur*ing* continuity of care and services for members who are in the process

[10] The MOU template can be found at: https://www.dhcs.ca.gov/services/ccs/Documents/WCM-MOU-Template-REVISED-March2018.pdf
[11] WIC Section 14094.7(d)(4)(C)

of aging out of CCS. The county CCS programs are required to provide input and collaborate with MCPs on the development of the transition plan. MCPs must submit transition plans to DHCS for approval.

C. Data and Information Sharing

1. Inter-County Transfer

County CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for Inter-County Transfers (ICTs), while MCPs utilize different data systems. In their respective MOUs, the MCPs and county CCS programs must set out protocols for the exchange of ICT data as necessary, including authorization data, member data, and case management information, to ensure an efficient transition of CCS members and allow for continuity of care of already approved service authorization requests, as required by this APL and applicable state and federal laws and regulations.

When a CCS-eligible member moves from one county to another, the county CCS program and MCP, pursuant to their respective MOUs, must exchange ICT data. County CCS programs continue to be responsible for providing transfer data, including clinical and other relevant data, from one county to another. When a CCS-eligible member moves out of a WCM county, the county CCS program must notify the MCP and initiate the data transfer request. The MCP is responsible for providing transfer data, including clinical and other relevant data for members to the county CCS program office. The *originating* county CCS program must then coordinate the sharing of CCS-eligible member data to the new county of residence. Similarly, when a member moves into a WCM county, the *originating* county CCS program must provide transfer data to the MCP as applicable.

2. MCP Reporting to County CCS Program

MCPs must timely refer and report the following to the county CCS program:

Determinations and Redeterminations

MCPs must provide to the county CCS program all medical utilization and other clinical data for purposes of completing the annual medical redetermination and other medical determinations, as needed for each CCS-eligible member.

NICU Acuity Assessment[12]

[12] See WCM FAQ, which can be found on the CCS WCM page of the DHCS website

MCPs must report to the county CCS program all members identified as meeting the criteria for the NICU acuity assessment in order to capture the CCS referral. MCPs must review authorizations and determine if services meet CCS NICU requirements.

High-Risk Infant Follow-Up Program
MCPs must report to the county CCS program all members identified as High-Risk Infant Follow-Up (HRIF) in order to capture the CCS referral. MCPs must also notify the county CCS program in writing of all CCS-eligible neonates, infants, and children up to three years of age that lose Medi-Cal coverage for HRIF services. *Notification must occur as soon as the MCP is made aware, but no later than* 15 calendar days of *being made aware,* of *a member no longer having Medi-Cal eligibility*.

D. Dispute Resolution and Provider Grievances

Disagreements between the MCP and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS.[13] The county CCS program must communicate all resolved disputes in writing to the MCP. If disputes between the MCP and the county CCS program cannot be resolved, the dispute must be referred to DHCS by either entity, via email to CCSRedesign@dhcs.ca.gov, for review and final determination.

MCPs must have a formal process to accept, acknowledge, and resolve provider disputes and grievances.[14] A CCS provider may submit directly to the MCP a dispute or grievance concerning the processing of a payment or non-payment of a claim by the MCP. The dispute resolution process must be communicated by each MCP to all of its CCS providers.

II. MCP RESPONSIBILITIES TO CCS-ELIGIBLE MEMBERS

A. Screening and Referrals

MCPs must provide screening, diagnostic, and treatment services in accordance with APL 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL, to identify potential CCS-eligible members.
MCPs must also refer potential CCS-eligible members to the county CCS program for a CCS eligibility determination if the members:

[13] WIC Section 14093.06(b)
[14] WIC Section 14094.15(d)

- Demonstrate potential CCS condition(s) as outlined in the CCS Eligibility Manual, including members who are suspected of having CCS condition(s) resulting from diagnostic services or who are undergoing diagnostics for CCS;[15]
- Present at the Emergency Department, provider, or facility for other primary conditions, and demonstrate potential CCS condition(s); or
- Are potentially MTP eligible.

B. Risk Level and Needs Assessment Process

MCPs must assess each CCS member's risk level and needs by performing a risk assessment process using means such as telephonic or in-person communication, review of utilization and claims processing data, or by other means. MCPs are required to develop and complete the risk assessment process for WCM members, newly CCS-eligible members, or new CCS members enrolling in the MCP. The risk assessment process must include a pediatric risk stratification process (PRSP) and, for high risk members, an Individual Care Plan (ICP).

All requirements are dependent on the member's risk level, as determined through the PRSP. Furthermore, nothing in this APL removes or limits the MCPs' existing survey or assessment requirements that the MCPs are responsible for outside of the WCM.

1. Pediatric Risk Stratification Process

MCPs must have a pediatric risk stratification mechanism, or algorithm, to assess the CCS-eligible member's risk level that will be used to classify members into high and low risk categories, allowing MCPs to identify members who have more complex health care needs.

MCPs are required to complete a risk stratification within 45 days of enrollment for all members, including new CCS members enrolling in the MCP and newly CCS-eligible members. The risk stratification will assess the member's risk level through:

- Review of medical utilization and claims processing data, including data received from the county and DHCS;
- Utilization of existing member assessment or survey data; and
- Telephonic or in-person communications, if available at the time of PRSP.

[15] See the CCS Medical Eligibility Guide at: https://www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx

Members who do not have any medical utilization data, claims processing data history, or other assessments and/or survey information available must be automatically categorized as high risk until further assessment data is gathered to make an additional risk determination. The PRSP must be submitted to DHCS for review and approval.

2. **Risk Assessment and Individual Care Plan Process**
MCPs must have a process to assess a member's current health, including CCS condition(s), to ensure that each CCS-eligible member receives case management, care coordination, provider referral, and/or service authorization from a CCS-paneled provider, as described below:

New Members and Newly CCS-Eligible Members Determined High Risk
Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of the member's ICP. Any risk assessment survey created by MCPs for the purposes of WCM is subject to review and approval by DHCS.

Risk Assessment
The risk assessment process must address:

- General health status and recent health care utilization. This may include, but is not limited to, caretaker self-report of child's health; outpatient, emergency room, or inpatient visits; and school days missed due to illness, over a specified duration of time;
- Health history. This may include, but is not limited to, both CCS and non-CCS diagnoses and past surgeries;
- Specialty provider referral needs;
- Prescription medication utilization;
- Specialized or customized durable medical equipment (DME) needs (if applicable);
- Need for specialized therapies (if applicable). This may include, but is not limited to, physical, occupational, or speech therapies, mental or behavioral health services, and educational or developmental services;
- Limitations of activities of daily living or daily functioning (if applicable); and
- Demographics and social history. This may include, but is not limited to, member demographics, assessment of home and school environments, and a cultural and linguistic assessment.

The risk assessment process must be tailored to each CCS-eligible member's age group. At the MCP's discretion, additional assessment questions may be added to identify the need for, or impact of, future health care services. These may include, but are not limited to, questions related to childhood developmental milestones, pediatric depression, anxiety or attention deficit screening, adolescent substance use, or adolescent sexual behaviors.

Individual Care Plan

MCPs must establish an ICP for all members determined to be high risk based on the results of the risk assessment process, with particular focus on *coordinated* specialty care, within 90 days of a completed risk assessment survey or other assessment, by telephonic and/or in-person communication.[16] The ICP must, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:

- Medical (primary care and CCS specialty) services;
- Mild to moderate or county specialty mental health services;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
- County substance use disorder or Drug Medi-Cal services;
- Home health services;
- Regional center services; and
- Other medically necessary services provided within the MCP network, or, when necessary, by an out-of-network provider.

The ICP must be developed by the MCP care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or the member's designated caregiver, as applicable. The ICP must indicate the level of care the member requires (e.g., no case management, basic case management and care coordination, or complex case management). The ICP must also include the following information, as appropriate, and only if the information has not already been provided as part of another MCP process:[17]

- Access instructions for families so that families know where to go for ongoing information, education, and support in order that they may

[16] WIC Section 14094.11(b)(4)
[17] WIC Section 14094.11(c)

understand the goals, treatment plan, and course of care for the CCS-eligible member and the family's role in the process; what it means to have primary or specialty care for the CCS-eligible member; when it is time to call a specialist, primary, urgent care, or emergency room; what an interdisciplinary team is; and what community resources exist;
- A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions;

- Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams*, as well as coordination of care plans across specialties* including mechanisms to track completion of follow up visits*, if applicable. For example, MCPs must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the MCP must follow up with the member to assist in planning next steps in care coordination understand barriers and make adjustments to the referrals if warranted. MCPs should also attempt to connect with the provider to whom the member was referred to and facilitate a warm hand off to necessary treatment. and*

  - Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the MCP.

  Further, the MCP must reassess a member's risk level and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

  <u>New Members and Newly CCS-Eligible Members Determined Low Risk</u>
  For new members and newly CCS-eligible members identified as low risk, the MCP must assess the member by telephonic and/or in-person communication within 120 calendar days of enrollment to determine the member's health care needs. The MCP is still required to provide care coordination and case management services to low risk members.

  The MCP must reassess a member's risk level and needs annually at the CCS eligibility redetermination or upon a significant change to a member's condition.

WCM Transitioning Members

For members transitioning into the WCM program, the MCP must complete the PRSP within 45 days of transition to determine each member's risk level. The MCP must also complete all required telephonic and/or in-person communication and ICPs for high risk members, and all required telephonic and/or in-person communication for low risk members, within one year of the transition. Additionally, the MCP must reassess a member's risk level and needs annually at the CCS eligibility redetermination, or upon a significant change to a member's condition.

MCPs must submit to DHCS for review and approval a WCM member phase-in transition plan establishing a process for completing all required telephonic or in-person communication and ICPs within one year of the transition.

Regardless of a member's risk level, all communications, whether by phone, mail, or other forms of communication, must inform the member and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and must identify the method by which providers will arrange for in-person assessments.[18]

MCPs must refer all members, including new members, newly CCS-eligible members, and WCM transition members who may have developed a new CCS eligible condition, immediately to the county for CCS eligibility determination and must not wait until the annual CCS medical eligibility redetermination period.

C. Case Management and Care Coordination[19]

MCPs must provide case management and care coordination*, including referrals to subspecialists, if not previously referred by the Primary Care Physician (PCP), and service authorizations* for CCS-eligible members and their families. *MCPs must ensure that case management is administered by their employees (e.g., nurse case managers) who have knowledge of, and receive adequate training on, the CCS program, and have clinical experience with CCS-eligible members or pediatric patients with complex medical conditions.*[20] MCPs that delegate the provision of CCS services to subcontractors *and network providers,* must ensure that all subcontractors *and network providers provide* case management and care coordination for members.

[18] See APL 99-005: Cultural Competency in Health Care – Meeting the Needs of a Culturally and Linguistically Diverse Population, or any superseding APL
[19] WIC Section 14094.11(b)(1)-(6)
[20] *WIC Section 14094.11(a)*

MCPs must allow members to access CCS-paneled providers within all of the MCP's subcontracted provider network for CCS services. MCPs must ensure that information, education, and support is continuously provided to CCS-eligible members and their families to assist in their understanding of the CCS-eligible member's health, other available services, and overall collaboration on the CCS-eligible member's ICP. MCPs must also coordinate services identified in the member's ICP, including:

- Primary and preventive care services with specialty care services;
- MTUs;
- EPSDT services, including palliative care;[21]
- Regional center services; and
- Home and community-based services.

1. **High Risk Infant Follow-up Program**
   The HRIF program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. MCPs are responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.[22]

2. **Age-Out Planning Responsibility**
   MCPs must maintain a process for preparing members approaching WCM age limitations, including identification of primary care and specialty care providers appropriate to the member's CCS qualifying condition(s).

   MCPs must identify and track CCS-eligible members for the duration of their participation in the WCM program and, for those who continue to be enrolled in the same MCP, for at least three years after they age-out of the WCM program, to the extent feasible.[23]

3. **Pediatric Provider Phase-Out Plan**

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[21] If the scope of the federal EPSDT benefit is more generous than the scope of a benefit discussed in a CCS N.L. or other guidance, the EPSDT standard of what is medically necessary to correct or ameliorate the child's condition must be applied. See APL 19-010*,* or any superseding APL.
[22] HRIF Eligibility Criteria is available at: https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx#medicalcriteria
[23] WIC Section 14094.12(j)

A pediatric phase-out occurs when a treating CCS-paneled provider determines that their services are no longer beneficial or appropriate to the treatment of the member. The MCPs must provide care coordination to CCS-eligible members in need of an adult provider when the CCS-eligible member no longer requires the services of a pediatric provider. The timing of the transition must be individualized to take into consideration the member's medical condition and the established need for care with adult providers.

D. Continuity of Care

MCPs must establish and maintain a process to allow members to request and receive continuity of care with existing CCS provider(s) for up to 12 months.[24] This APL does not in any way limit the MCP's obligation to fully comply with the requirements of HSC Section 1373.96 and all applicable APLs regarding continuity of care. The continuity of care requirements extend to the MCP's network providers and subcontractors. Sections 1 through 4 below include additional continuity of care requirements that only pertain to the WCM program.

1. Specialized or Customized Durable Medical Equipment

If a member has an established relationship with a specialized or customized DME provider, the MCP must provide access to that provider for up to 12 months.[25] The MCP is required to pay the DME provider at rates that are at least equal to the applicable CCS fee-for-service (FFS) rates, unless the DME provider and the MCP mutually enter into an agreement on an alternative payment methodology. The MCP may extend the continuity of care period beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.[26]

Specialized or customized DME must be:

- Uniquely constructed or substantially modified solely for the use of the member;
- Made to order or adapted to meet the specific needs of the member; and
- Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

2. Continuity of Care Case Management[27]

[24] WIC Section 14094.13
[25] WIC Section 14094.13(b)(2)(A)
[26] WIC Section 14094.13(b)(3)
[27] WIC Section 14094.13(e), (f), and (g)

MCPs must ensure CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. MCPs must meet this requirement by, at the request of CCS-eligible members, their families, or designated caregivers, allowing continuity of care case management and care coordination from the CCS-eligible member's existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the MCP. In the event the county PHN is unavailable, the MCP must provide the member with an MCP case manager who has received adequate training on the county CCS program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.

At least 60 days before the transition of CCS services to the MCP, the MCP must provide a written notice to all CCS-eligible members explaining their right to continue receiving case management and care coordination services. The MCP must send a follow-up notice 30 days prior to the start of the transition. These notices must be submitted to DHCS for approval.

3. **Authorized Prescription Drugs**
   CCS-eligible members transitioning into MCPs must be allowed continued use of any currently prescribed drug that is part of their prescribed therapy for the CCS-eligible condition(s) immediately prior to the date of enrollment, whether or not the prescription drug is covered by the MCP. The CCS-eligible member must be allowed to use the prescribed drug until the MCP and the prescribing physician have completed an assessment, created a treatment plan, and agree that the particular drug is no longer medically necessary, or the prescription drug is no longer prescribed by the county CCS program provider.[28] *In such cases, the MCP must send a Notice of Action to the CCS-eligible member informing them of the service change, as well as their appeal rights.*[29]

4. **Extension of Continuity of Care Period**[30, 31]
   MCPs, at their discretion, may extend the continuity of care period beyond the initial 12-month period. MCPs must provide CCS-eligible members with a written notification 60 days prior to the end of the continuity of care period

[28] WIC Section 14094.13(d)(2)
[29] *See APL 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates, or any superseding APL.*
[30] HSC Section 1373.96
[31] WIC Section 14094.13(k)

informing members of their right to request a continuity of care extension and the WCM appeal process for continuity of care limitations.

The notification must be submitted to DHCS for approval and must include:

- The member's right to request that the MCP extend of the continuity of care period;
- The criteria that the MCP will use to evaluate the request; and
- The appeal process should the MCP deny the request (see section E below).

In addition to the WCM continuity of care protections set forth above, MCP members also have continuity of care rights under current state law as described in APL 18-008*,* Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care, or any superseding APL.

E. Grievance, Appeal, and State Fair Hearing Process

MCPs must ensure that all members are provided information on grievances, appeals, and state fair hearing (SFH) rights and processes. All CCS-eligible members enrolled in managed care must be provided the same grievance, appeal, and SFH rights as other MCP members. This does not preclude the right of the CCS member to appeal or be eligible for a fair hearing regarding the extension of a continuity of care period.[32]

MCPs must have timely processes for accepting and acting upon member grievances and appeals. Members appealing a CCS eligibility determination must appeal to the county CCS program. MCPs must also comply with the requirements pursuant to APL *21-004:* Standards for Determining Threshold Languages, *Nondiscrimination* Requirements *and Language Assistance Services*, or any superseding APL.

As stated above, CCS-eligible members and their families/designated caregivers have the right to request extended continuity of care with the MCP beyond the initial 12-month period. MCPs must process these requests like other standard or expedited prior authorization requests according to the timeframes contained in APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, or any superseding APL.

[32] WIC Section 14094.13(j)

If MCPs deny requests for extended continuity of care, they must inform members of their right to further appeal these denials with the MCP and of the member's SFH rights following the appeal process as well as in cases of deemed exhaustion. MCPs must follow all noticing and timing requirements contained in APL 17-006, or any superseding APL, when denying extended continuity of care requests and when processing appeals. As required in APL 17-006, if MCPs make changes to any of the noticing templates, they must submit the revised notices to DHCS for review and approval prior to use.

F. Major Organ Transplants

MCPs are required to cover all medically necessary major organ transplants (MOT) for CCS-eligible members as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the manual.[33] *The MCP must refer CCS-eligible members to a CCS-approved SCC for an evaluation within 72 hours of the member's PCP or specialist identifying the CCS-eligible member as a potential candidate for a MOT. MCPs must authorize the request for the MOT after the SCC confirms that the member is a suitable candidate for the MOT.*[34]

G. Transportation

MCPs are responsible for authorizing CCS Maintenance and Transportation (M&T), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).[35]

Reimbursements for M&T expenses are available to the CCS-eligible member/family in accordance with CCS N.L. 03-0810. MCPs must provide and authorize the CCS M&T benefit for CCS-eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition(s) when the cost of M&T presents a barrier to accessing authorized CCS services. M&T services include meals, lodging, and other necessary costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810*, or any superseding version of that N.L*. These services include, but are not limited to, M&T for out-of-county and out-of-state services*, and reimbursement for private car conveyance at the Internal Revenue Service (IRS) standard mileage rate for medical transportation in effect on the date the travel occurred.*

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[33] *See the Medi-Cal Provider Manual - Transplants at:* https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplant.pdf
[34] *HSC Section 1367.01*
[35] See APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services, or any superseding APL

If the CCS-eligible member or the member's family paid for M&T expenses up front, the MCP must approve and reimburse the member or the member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received. MCPs are required to submit updated policies and procedures (P&P) outlining required documentation.

MCPs must also comply with all requirements listed in *the DHCS Contract and* APL 17-010, or any superseding version of that APL, for CCS-eligible members to obtain NEMT and NMT *exceeding the CCS M&T benefit as set forth in CCS N.L. 03-0810, or* for services not related to *a member's* CCS-eligible condition(s).

H. Out-of-Network Access

MCPs must provide all medically necessary services by CCS paneled providers, which may require the member to be seen out of network. MCPs must allow CCS-eligible members access to out-of-network providers in order to obtain medically necessary services if the MCP has no specialists that treat the CCS-eligible condition(s) within the MCP's provider network, or if in-network providers are unable to meet timely access standards. CCS-eligible members and providers are required to follow the MCP's authorization policy and procedures to obtain appropriate approvals before accessing an out-of-network provider. MCPs must ensure that CCS-eligible members requesting services from out-of-network providers are provided accurate information on how to request and seek approval for out-of-network services. MCPs cannot deny out-of-network services based on cost or location. Transportation must be provided for members obtaining out-of-network services. These out-of-network access requirements also apply to the MCP's subcontracted provider networks.

The MCP and their subcontracted provider networks must ensure members have access to all medically necessary services related to their CCS condition(s). If CCS-eligible members require services or treatments for their CCS condition(s) that are not available in the MCP's or their subcontracted provider networks, the MCP must identify, coordinate, and provide access to a CCS-paneled specialist out-of-network.

I. Advisory Committees

MCPs must meet quarterly with a Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC must also include local providers, including, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information

centers.[36] Members serving on this advisory committee may receive a reasonable per diem payment to enable in-person participation in the advisory committee.[37] A representative of this committee will be invited to serve as a member of the statewide DHCS CCS stakeholder advisory group.

MCPs must also meet quarterly with a Clinical Advisory Committee composed of the MCP's chief medical officer or equivalent, the county CCS medical director or *designee*, and at least four CCS-paneled providers to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS conditions.[38]

III. WCM PAYMENT STRUCTURE

A. Payment and Fee Rate

MCPs are required to pay providers at rates that are at least equal to the applicable CCS FFS rates, unless the provider and the MCP mutually enter into an agreement on an alternative payment methodology.[39] MCPs are responsible for authorization and payment of all NICU and CCS NICU claims and for conducting NICU acuity assessments and authorizations in all WCM counties.

MCPs are responsible for NICU acuity assessment, authorization, and payment function activities in all WCM counties. The MCP will review authorizations and determine whether or not services meet CCS NICU requirements. MCPs are also required to assume responsibility of coverage for PICU/NICU eligible newborns through their second month of life when the newborn's mother is Medi-Cal eligible and enrolled in the MCP.

IV. MCP RESPONSIBILITIES TO DHCS

A. Network Certification[40]

MCPs and their subcontracted provider networks are required to meet specific network certification requirements while participating in the WCM program, which includes having an adequate network of CCS-paneled providers to serve the CCS-eligible population including physicians, specialists, allied professionals,

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[36] WIC Section 14094.7(d)(3)
[37] WIC Section 14094.17(b)(2)
[38] WIC Section 14094.17(a)
[39] WIC Section 14094.16(b)
[40] These requirements are further outlined in the APL *21-006*: Network Certification Requirements, or any superseding APL

SCCs, hospitals, home health agencies, and specialized and customizable DME providers.

The WCM network certification requires MCPs to submit updated policies and procedures and their CCS-paneled provider networks via a WCM Provider Network Reporting Template.[41]

Subcontracted provider networks that do not meet WCM network certification requirements will be excluded from participating in the WCM until DHCS determines that all certification requirements have been met. MCPs are required to provide oversight and monitoring of all subcontracted provider networks to ensure network certification requirements for WCM are met.

In accordance with APL *21-006*, or any superseding APL, WCM MCPs must request to add subcontracted provider networks to their WCM network no later than *the Annual Network Certification submission date provided in the APL.*

B. CCS Paneling and Provider Credentialing Requirements

Physicians and other provider types must be CCS-paneled with full or provisional approval status.[42] MCPs cannot panel CCS providers; however, they must ensure that CCS providers in their provider network have an active panel status. MCPs must direct providers who need to be paneled to the CCS Provider Paneling website.[43] MCPs can view the DHCS CCS-paneled provider list online to ensure providers are credentialed and continue contracting with additional CCS-paneled providers.[44]

MCPs are required to verify the credentials of all contracted CCS-paneled providers to ensure the providers are actively CCS-paneled and authorized to treat CCS-eligible members. MCPs' written policies and procedures must follow the credentialing and re-credentialing guidelines contained in APL 19-004: Provider Credentialing/Re-credentialing and Screening Enrollment, or any superseding APL. MCPs must develop and maintain written policies and procedures that pertain to the initial credentialing, re-credentialing, recertification, and reappointment of providers within their network.

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[41] The WCM Provider Network Reporting Template will be provided to MCPs upon request
[42] See the Medi-Cal Provider Manual on CCS Provider Paneling Requirements, which is available at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx
[43] Children's Medical Services CCS Provider Paneling is available at: https://cmsprovider.cahwnet.gov/PANEL/index.jsp
[44] The CCS Paneled Providers List is available at: https://cmsprovider.cahwnet.gov/prv/pnp.pdf

C. Utilization Management

MCPs must develop, implement, and update, as needed, a utilization management (UM) program that ensures appropriate processes are used to review and approve medically necessary covered services. MCPs are responsible for ensuring that the UM program includes the following items:[45]

- Procedures for pre-authorization, concurrent review, and retrospective review;
- A list of services requiring prior authorization and the utilization review criteria;
- Procedures for the utilization review appeals process for providers and members;
- Procedures that specify timeframes for medical authorization; and,
- Procedures to detect both under- and over-utilization of health care services.

D. MCP Reporting to DHCS

1. **Quality Performance Measures**
   DHCS will develop pediatric plan performance standards and measurements, including health outcomes of children with special health care needs. MCPs are required to report data on the identified performance measures in a format and manner specified by DHCS.
2. **Reporting and Monitoring**
   MCPs are required to report WCM encounters as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for encounter data reporting. MCPs are also required to report all contracted CCS-paneled providers as outlined in the most recent DHCS Companion Guide for X12 Standard File Format for provider network data. Both companion guides can be attained by emailing the Encounter Data mailbox at MMCDEncounterData@dhcs.ca.gov. MCPs must submit additionally required data in a form and manner specified by DHCS and must comply with all contractual requirements.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been

[45] See the COHS Boilerplate Contract, Exhibit A, Attachment 5, Utilization Management. The COHS Boilerplate Contract is available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

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.[46] 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 Dana Durham

Dana Durham Chief
Managed Care Quality and Monitoring Division

[46] For more information on subcontractors and network providers, including the definition and requirements applicable, see APL 19-001, or any superseding APL

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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 12, 2021

ALL PLAN LETTER 21-008

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TRIBAL FEDERALLY QUALIFIED HEALTH CENTER PROVIDERS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding the implementation of the Tribal Federally Qualified Health Center (Tribal FQHC) provider type in Medi-Cal with an effective date of January 1, 2021. This APL also provides guidance regarding reimbursement requirements for Tribal FQHC provider types.

BACKGROUND:
The Centers for Medicare and Medicaid Services (CMS) allows Indian Health Care Providers (IHCP) operating under the authority of the Tribal Indian Self-Determination and Education Assistance Act to participate in Medi-Cal as one of several clinic provider types, including but not limited to:[1]

- Indian Health Services Memorandum of Agreement (IHS-MOA) clinic;
- FQHC (using Health Resources Services Administration criteria);
- Tribal FQHC (using CMS criteria); and
- Community clinic.

California must assure that IHCPs are reimbursed in accordance with federal law.[2] The rules for each specific provider type, including payment rates, covered services, billable providers, allowances for the number of reimbursable visits per day, and service sites are set forth in California's Medicaid State Plan. IHCP may operate as only one of the provider types listed above. For instance, IHCPs cannot be both an IHS-MOA and a Tribal FQHC.

[1] See 25 United States Code (U.S.C.) Chapter 46 (Public Law 93-638). The U.S.C. is searchable at the following link: https://uscode.house.gov/browse.xhtml.
[2] See 42 U.S.C. section 1396u-2(h)(2)(C) and 42 Code of Federal Regulations (C.F.R.) section 438.14(c). 42 C.F.R. 438.14(c) is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=4f517849d06685b38053c59d244f961a&mc=true&node=pt42.4.438&rgn=div5.

CMS recognizes the Tribal FQHC as a new clinic provider type with corresponding service site parameters. IHCPs participating in Medi-Cal as IHS-MOA provider types may elect to enroll as a Tribal FQHC in accordance with State Plan Amendment (SPA) 20-0044, which sets forth the reimbursement methodology for Tribal FQHCs.[3,4]

POLICY:
Effective January 1, 2021, MCPs are required to make payments to Tribal FQHC providers for eligible services provided on or after the implementation date, in accordance with the Alternate Payment Methodology (APM) and reimbursement requirements described below.[5] MCP contracts with Tribal FQHCs must include all covered and eligible services available at the Tribal FQHC with the exception of dental services, which are not managed care reimbursable services. MCPs may not limit their contracts to a specific set of those services. MCPs are reminded of their obligations to attempt to contract with IHCPs, to comply with prompt payment requirements, and the allowance for non-contracted Tribal FQHC provider access, where applicable.

Alternate Payment Methodology
MCPs must reimburse IHCPs that are currently enrolled as IHS-MOA clinic providers that elect to participate in Medi-Cal as Tribal FQHCs utilizing an APM.

Where the APM applies, MCPs must pay Tribal FQHC providers as follows for each visit:

1) For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent of the Medicare FQHC prospective payment system rate.[6]

2) For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)".[7]

[3] SPA 20-0044 can be accessed at the following link: https://www.dhcs.ca.gov/Documents/SPA-20-0044-Approval.pdf
[4] See Attachment 2 for a list of IHCPs that are enrolled in Medi-Cal as Tribal FQHCs. Attachment 2 will be added to this APL at a later date.
[5] See Attachment 1 for applicable APM.
[6] See 42 U.S.C. § 1395w-4(e)(6)(A)(ii).
[7] See Attachment 1 for the specific Non-Dual rate.

Tribal FQHCs must be reimbursed at the applicable rate for up to three visits per day in any combination of different visits in the following visit categories: medical, mental health, and ambulatory. For example, Tribal FQHCs can be reimbursed for:

- A combination of three (3) different medical visits with a primary care physician, nurse practitioner, and a specialist;
- A combination of three (3) different mental health visits with a psychiatrist, psychologist, and a licensed clinical social worker;
- A combination of three (3) different ambulatory visits for audiology, physical therapy, and optometry services.

The visit categories, service types, and billable providers that are allowed reimbursement at the APM are further detailed in the Medi-Cal Provider Manual.[8] To the extent that the Medi-Cal Provider Manual conflicts with this APL, the requirements of this APL shall apply.

Alternate Payment Methodology Exclusions

Please note that certain MCP covered services will continue to be reimbursed outside the APM, including Non-Medical Transportation, Non-Emergency Medical Transportation, and Pharmacy.

This policy does not require MCPs to provide services that are carved-out of the MCP's contract with DHCS. For example, MCPs will not be responsible for reimbursing Tribal FQHCs for dental services not otherwise covered by the MCP contract.

Tribal FQHC providers must follow DHCS' FQHC established billing practices for services outside the MCP's responsibility.[9]

Reimbursement Requirements

In order for Tribal FQHCs to be eligible for APM reimbursement by MCPs pursuant to this APL, services must be covered benefits under the MCP's contract with DHCS and must not exceed the allowable limit of up to three (3) visits per day, per member, in any combination of medical, mental health, and ambulatory visits. Services provided offsite by Tribal providers and non-Tribal providers that are contractors of the Tribal FQHC are reimbursable in accordance with the APM.

APM rates will be effective for a calendar year, and may have a retroactive effective date. Therefore, MCPs are required to pay the most current applicable payments as described

[8] See the Medi-Cal Provider Manual. A link to the Medi-Cal Provider Manual will be added to this APL at a later date.
[9] For guidance, see the Medi-Cal Provider Manual. A link to the Medi-Cal Provider Manual will be added to this APL at a later date.

in this APL during the calendar year for which the rate applies and as an interim rate in a subsequent calendar year if an updated APM has not been published.[10] MCPs must ensure that interim payments are reconciled to the applicable updated rate for that calendar year in accordance with contractual prompt payment requirements. MCPs will receive reimbursement for services paid to Tribal FQHCs through the submission of the Consolidated Supplemental File.[11]

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an e-mail confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The e-mail confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

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.[12] These requirements must be communicated by each MCP to all subcontractors and network providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[10] See Attachment 1 for current applicable payments.
[11] Submission of the Consolidated Supplemental File is similar to the MCP payment process established under APL 17-020.
[12] For more information on Subcontractors and Network Providers, including the definition and requirements applicable, see APL 19-001, and any subsequent APLs on this topic. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

August 20, 2021

Jacey Cooper
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: TN 21-0017

Dear Ms. Cooper:

We have reviewed the proposed California State Plan Amendment (SPA) to Attachment 4.19-B, CA-21-0017, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 1, 2021. This SPA, effective July 1, 2021, allows for the continuation of an add-on to the fee-for-service (FFS) fee schedule rates for eligible ground emergency medical transports (GEMT) provided to Medi-Cal patients.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt at 303-844-6218 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21 — 0017

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Title 42 CFR 447 Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 4,166 (in thousands)
b. FFY 2022 $ 12,497 (in thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 29, Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 29, Attachment 4.19-B, pages 1-2

10. SUBJECT OF AMENDMENT

One-year reimbursement rate add-on for eligible ground emergency medical transports with dates of service between July 1, 2021 and June 30, 2022.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Jacey Cooper

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: July 1, 2021

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 1, 2021

18. DATE APPROVED: August 20, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Director, Division of Reimbursement Review

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

FORM CMS-179 (07/92)

Instructions on Back

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport (GEMT) providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Healthcare Common Procedure Coding System (HCPCS) Codes, as described below, effective July 1, 2020 through June 30, 2021, and July 1, 2021 through June 30, 2022. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with HCPCS Codes A0429 BLS Emergency, A0427 ALS Emergency, and A0433 ALS2, A0434 Specialty Care Transport, and A0225 Neonatal Emergency Transport. An "emergency medical transport" does not occur when, following evaluation of a patient, a transport is not provided.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Methodology

For SFYs 2020-21 and 2021-22, the reimbursement rate add-on is fixed. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the HCPCS Code. The resulting total payment amount for HCPCS Codes A0429, A0427, A0433, and A0434 is $339.00, and for HCPCS Code A0225 is $400.72. The add-on is paid for each eligible HCPCS Code on a per-claim basis.

Service Code	Description	Current Payment*	Add On Amount	Resulting Total Payment
A0429	Basic Life Support, Emergency	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00
A0434	Specialty Care Transport	$118.20	$220.80	$339.00
A0225	Neonatal Emergency Transport	$179.92	$220.80	$400.72

*These are the base rates associated with these codes, but are subject to further adjustments pursuant to the State Plan.

The resulting total payment amount listed in the table above for HCPCS Codes A0429, A0427, A0433, A0434 and A0225 are considered the Rogers rate, which managed care organizations shall pay noncontract managed care emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code, for each state fiscal year the FFS reimbursement rate add-on is effective.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
18. Approve Modifications to CalOptima Policy MA.7007: Access and Availability

Contacts
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action
Approve modifications to Policy MA.7007: Access and Availability, in accordance with CalOptima's regular review process and regulatory requirements.

Background/Discussion
CalOptima regularly reviews its policies and procedures to ensure that they are up-to-date and aligned with federal and state health care program requirements, contractual obligations laws, and CalOptima operations.

Policy MA.7007: Access and Availability establishes required access and availability standards, including provider network adequacy, for Members to obtain effective, appropriate, and timely access to care and describes the process that CalOptima shall use for monitoring network adequacy.

Fiscal Impact
The recommended action to approve changes to MA.7007 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 laws, regulations, rules, and accreditation standards, 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.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1_MA.7007 Access and Availability (Redlined and Clean)
2. Attachment 2_Policy MA.7007 Access and Availability - Summary of Changes

/s/ Michael Hunn — *04/28/2022*
Authorized Signature — **Date**

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Policy:	MA.7007
Title:	**Access and Availability**
Department:	Medical ~~Affairs~~Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20220505 BOD Review Only

I. PURPOSE

This policy establishes required access and availability standards, including Provider Network adequacy, for Members to obtain effective, appropriate, and timely access to care and describes the process which CalOptima shall use for monitoring network adequacy.

II. POLICY

A. General Access

1. CalOptima shall evaluate CalOptima's and it's Health Network's compliance with the standards outlined in this Policy. Unless otherwise stated, each access and availability standard outlined herein shall have a minimum performance threshold of ~~ninety~~eighty percent (~~90~~80%).

2. CalOptima and its Health Networks shall not discriminate against Members or individuals who are ~~able~~ eligible to enroll, on the basis of health status or need for health care services, race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental disability.

3. CalOptima and its Health Networks shall ensure access for disabled Members which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

   a. If a Provider cannot meet the minimum access standards for disabled Members, CalOptima and its Health Networks shall coordinate the referral to a Provider who does have the appropriate access standards.

4. CalOptima and its Health Networks shall ensure that Providers offer flexibility in scheduling Covered Services to accommodate the needs of Members with disabilities.

5. If a Provider has a moral or ethical objection to provide a Covered Service to a Member, CalOptima, or a Health Network, shall refer the Member to a different Provider.

6. If a Health Network refers a Member to a different Provider pursuant to Section II.~~G~~A.8 of this Policy, CalOptima shall not incur any additional expense as a result of such referral.

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7. CalOptima shall refer Members to, or assist Members in locating, available and accessible contracted Providers in neighboring service areas or out-of-network providers for obtaining Covered Services in a timely manner appropriate for the Member's needs.

   a. Out-of-network providers shall be made available to Members if CalOptima and its Health Networks are unable to arrange for an in-person visit with a contracted Provider.

~~7.~~8. If Covered Services are unavailable to the Member within the ~~network~~Provider Network, CalOptima, or a Health Network, shall arrange for the provision of specialty services from ~~specialists~~Specialty Care Providers outside of the network in a timely manner and, in accordance with CalOptima policy GG.1508: Authorization and Processing of Referrals.

9. CalOptima and its Health Networks shall ensure that contracting Providers offer CalOptima Members hours of operation that are:

   a. Convenient to the population;

   b. No less than the hours of operation offered to commercial members or comparable to Medi-Cal Fee-For-Service, if the Provider services only Medi-Cal Members, where applicable; and

   c. Do not discriminate against Medicare Members.

10. Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima Plan. A Member may self-refer to an out-of-network Provider to receive Sensitive Services, without Prior Authorization, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

11. Minor Consent Services: Minor Consent Services shall be available to a Member under the age of 18 in a confidential manner without parental consent, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

12. Women Health Services: CalOptima shall ensure female Members have direct access to a women's health specialist within the network to Provider women's routine and preventive health services and such access may be in addition to the Member's Primary Care Practitioners (PCP).

13. Family Planning Services: Family Planning Services shall be available to a Member, pursuant to CalOptima Policy GG.1118: Family Planning Services, Out-of-Network and consistent with Title 42 CFR section 441.20. A Member may self-refer to any Qualified Family Planning Practitioner, including an out-of-network practitioner to receive Family Planning Services.

14. Behavioral Health Care: Behavioral Health Care Services for OneCare Connect Members shall be available to a Member, pursuant to CalOptima Policy CMC.6033: Behavioral Health Services for OneCare Connect Members.

B. Network Providers

1. CalOptima and its Health Networks must maintain an appropriate network of specific Provider types to ensure the CalOptima's network has the capacity to provide all Medically Necessary Covered Services for current and anticipated membership.

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2. CalOptima shall meet federal requirements for access to Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services.

   a. If FQHC and RHCs services are not available in the Provider Network, CalOptima shall authorize out-of-network services subject to the prevailing Medicare Advantage payment requirements for out-of-network services.

3. CalOptima shall permit Indian Members eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as a PCP if the Indian Care Provider has capacity to Provide such services regardless of whether the Indian Health Care Provider is in or out of network.

   a. CalOptima shall demonstrate that there are sufficient Indian Health Care Providers in the Provider Network to ensure timely access to care for Indian Members who are eligible to receive services, where applicable.

4. CalOptima shall develop and execute a Memorandum of Understanding (MOU) with County Social Services Agency responsible for In-Home Supportive Services (IHSS) that reflects an agreement between CalOptima and the County Social Services Agency.

5. Certified Nurse-Midwife and Certified Nurse Practitioner Services: If Certified Nurse-Midwife services, as described in CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, CalOptima Direct, or Certified Nurse Practitioner services are not available to a Member; a Member may self-refer to an out-of-network Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.

6. CalOptima shall take into consideration the following Provider types when evaluating adequate access to Covered Services:

   a. Primary Care Practitioners (PCPs):

      i. OB/GYNs may, but are not required, to contract with CalOptima as a PCP, if desired.

      ii. Members may select an OB/GYN as their PCP, as long as the Provider agrees to serve as a PCP.

   b. High Volume Specialists:

      i. On an annual basis, CalOptima shall identify high-volume specialists by assessing the volume of claims and encounters by specialty type in a previous calendar year. Specialties with the highest utilization shall be determined as a high-volume specialist. (Obstetrics/gynecology specialists shall be categorized as a PCP and a high-volume specialist, in accordance with industry standards.)

   c. High Impact Specialists:

      i. On an annual basis, CalOptima shall identify high-impact specialists by a) identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or b) identifying practitioner types where treatment requires significant resources.

   d. Mental Health (Non-Physician) Outpatient Specialists:

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i. High Volume Mental Health Provider: The following provider types are considered High-Volume Mental Health (Non-Physician) Providers : psychologists and licensed clinical social workers.

e. Hospitals;

f. Pharmacies;

g. Long Term Support Services (LTSS):

i. CalOptima shall contract with Long Term Care Facilities in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

h. Community-Based Adult Services (CBAS) Centers:

i. CalOptima shall ensure that every CBAS provider is within the Service Area approved by the California Department of Aging (CDA) as a CBAS provider as of July 1, 2012, is included in the Provider Network, to the extent that the CBAS provider remains licensed, certified, operating, and meets CalOptima's credential and quality standards.

ii. If CalOptima determines that additional CBAS providers are necessary to meet the needs of its Members, CalOptima may extend a contract to any CBAS provider certified by the CDA after July 1, 2012. CalOptima shall consider a Member's relationship with previous CBAS providers when ensuring access to CBAS. CBAS providers certified by the CDA after July 1, 2012 are not required to be included in the Provider Network.

iii. If CalOptima has assessed a Member and determines that the Member is eligible for CBAS services and there is insufficient CBAS center capacity in the area, CalOptima may authorize unbundled services and facilitate utilization through care coordination in accordance with CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes.

7. CalOptima shall take the following into consideration:

a. Geographic location of Providers and Members accounting for distance, travel time, and mode of transportation when evaluating adequate access to Covered Services.

b. Members' and Practitioners' language and gender when evaluating adequate access to Covered Services.

c. The number of Providers who are not accepting new patients when evaluating adequate access to Covered Services.

d. Anticipated Member enrollment numbers when evaluating adequate access to Covered Services.

e. Expected utilization of services, in light of characteristics and health care needs of CalOptima Members.

C. Timely Access

1. Emergency Services: Emergency ~~services~~Services shall be available immediately to a Member twenty-four (24) hours a day, seven (7) days a week.

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a. CalOptima and its Health Networks shall cover emergency medical services without ~~prior authorization~~Prior Authorization.

b. CalOptima and its Health Networks shall have a designated emergency service facility within the Service Area, providing care twenty-four (24~~).~~) hours a day, seven (7~~).~~) days a week. This designated emergency service facility will have one (1) or more physicians and one (1) nurse on duty in the facility at all times.

c. CalOptima and its Health Networks shall provide adequate follow-up care for those Members who have been screened in the Emergency Room, in accordance with CalOptima Policy GG.1122: Follow-up for Emergency Department Care.

d. CalOptima and its Health Networks shall ensure that a Provider is available twenty-four (24) hours a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care to coordinate the transfer of stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies MA.6030: Transition of Care and CMC.6030: Transition of Care.

2. CalOptima and its Health Networks shall ensure that Members have effective and appropriate access to Covered Services in a timely manner, in accordance with the standards of this Policy. CalOptima shall evaluate CalOptima's and Health Network's compliance with the appointment access standards against a minimum performance threshold of ~~ninety~~eighty percent (~~90~~80%), unless otherwise indicated.

a. Urgent Care Services: Available within twenty-four (24) hours of the request for appointment

b. Primary Care Appointments:

~~a. Monitoring of primary care appointments shall include the monitoring of all primary care practitioners (PCPs) in CalOptima's provider network.~~

PRIMARY CARE APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointment for services that DO NOT require ~~prior authorization~~Prior Authorization	Available within forty-eight (48) hours of the request for appointment	~~90~~80%
Non-Urgent Primary Care (including Obstetrics/Gynecology Primary Care~~).~~) Appointments	Available within ten (10) business days of request for appointment	~~90~~80%
Routine Physical Exams and Health Assessments: Appointments for ~~routine physical exams~~Routine Physical Exams and health assessments	Available within thirty (30) calendar days of request for appointment	~~90~~80%

c. Specialty and Ancillary Care Appointments:

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i. Monitoring of specialty care appointments shall, at minimum, include the monitoring of the following ~~specialty care providers~~Specialty Care Providers: Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialist/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, Podiatry and Pulmonology.

ii. Monitoring of ancillary appointments shall, at minimum, include the monitoring of the following: ~~laboratories, occupational therapy,~~ physical ~~therapy, radiology centers~~therapists, mammography providers, and ~~speech therapy~~MRI providers.

SPECIALTY AND ANCILLARY APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointment for services that DO NOT require Prior Authorization	Available within forty-eight (48) hours of the request for appointment	80%
Urgent appointments for services that DO require Prior Authorization	Available within ninety-six (96) hours of the request for appointment	~~90~~80%
Non-Urgent Specialty Care (including Obstetrics/Gynecology Specialty Care~~):~~) Appointments	Available within fifteen (15) business days of request for appointment	~~90~~80%
First Prenatal Visit: Appointments for the first prenatal visit	Available within two (2) weeks of request for appointment	~~90~~80%
Non-Urgent Ancillary Services: Appointments for non-urgent ~~ancillary services~~Ancillary Services for the diagnosis or treatment of illness, injury, or other health conditions	Available within fifteen (15) business days of request for appointment	~~90~~80%

d. ~~Routine Behavioral~~Mental Health ~~Services:~~Outpatient Service Appointments:

~~a. Monitoring of timeliness of Behavioral~~Mental Health Services ~~shall, at minimum, include the following:~~

i. ~~(~~Non-Physician ~~Behavioral Health Providers)~~ Outpatient Practitioners: Psychologist and Licensed Clinical Social Worker.

ii. Mental Health Services Provider (Physician ~~Behavioral Health Provider:~~): Psychiatrist

ROUTINE BEHAVIORAL HEALTH SERVICES		
Description	**Standard**	**Minimum Performance Level**
Appointment for ~~routine care~~Routine Care with a ~~non- physician behavioral health care~~ Mental Health (Non-Physician) Outpatient Services Provider	Available to a Member within ten (10) business days after the date of the request	~~90~~80%

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ROUTINE BEHAVIORAL HEALTH SERVICES		
Description	**Standard**	**Minimum Performance Level**
Appointment for follow-up ~~routine care~~Routine Care with a ~~non-physician behavioral health care provider (i.e. psychologists and Licensed Clinical Social Workers (LCSW)~~Mental Health (Non-Physician) Outpatient Services Provider	Members have a follow-up visit with a ~~non-physician behavioral health care provider~~Mental Health (Non-Physician) Outpatient Services Provider within twenty (20) calendar days of initial visit for a specific condition	~~60~~80%
Appointment for follow-up ~~routine care~~Routine Care with a ~~physician behavioral health care provider~~ Mental Health (~~Non-~~Physician) Outpatient Services Provider	Members have a follow-up visit with a ~~physician behavioral health care provider~~Mental Health (~~Non-~~Physician) Outpatient Services Provider within thirty (30) calendar days of initial visit for a specific condition	~~60%~~80%

e. Exceptions to Time Frames for Appointments

i. The time frame to obtain an appointment for the services described in Sections II.~~K.1through II.K.3~~C.2 of this Policy may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice, and consistent with professionally recognized standards of practice, has determined and documented in the Member's record that a longer waiting time will not have a detrimental impact on the Member's health.

ii. A Provider may offer an appointment for non-urgent Primary Care within the same or next business day from the time the Member requests the appointment, and advance scheduling of an appointment at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

iii. Preventive care services and periodic follow-up care for the services described in Sections II.~~K.1through II.K.3~~C.2 of this Policy may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of their practice.

iv. Subsequent routine appointments: Appointments for subsequent routine appointments for prenatal visits shall be available to a Member and shall be scheduled in advance in accordance with American College of Obstetricians and Gynecologists (ACOG) guidelines. All Medically Necessary services for pregnant Members will be covered. The most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) will be utilized as the minimum measure of quality for perinatal services by CalOptima and its Health Networks.

~~3.1.Health Risk Assessment (HRA): Appointment for HRA shall be completed in accordance with CalOptima Policies MA.6022: Initial and Annual Health Risk Assessment and CMC.6031: Health Risk Assessment.~~

v. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule an appointment, the Provider shall promptly reschedule the appointment in a

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manner appropriate to the Member's health care needs and that ensures ~~continuity~~Continuity of ~~care~~Care consistent with good professional practice.

3. Health Risk Assessment (HRA): Appointment for HRA shall be completed in accordance with CalOptima Policies MA.6022: Initial and Annual Health Risk Assessment and CMC.6031: Health Risk Assessment.

4. In-office wait times shall not exceed forty-five (45) minutes before a Member is seen by a Provider.

~~1. Certified Nurse-Midwife and Certified Nurse Practitioner Services: If Certified Nurse-Midwife services, as described in CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, CalOptima Direct, or Certified Nurse Practitioner services are not available to a Member, a Member may self-refer to an out-of-network Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.~~

~~8.1.Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima Plan. A Member may self-refer to an out-of-network Provider to receive Sensitive Services, without Prior Authorization, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.~~

~~9.1.Family Planning Services: Family Planning Services shall be available to a Member, pursuant to CalOptima Policy GG.1118: Family Planning Services, Out-of-Network. A Member may self-refer to any Qualified Family Planning Practitioner, including an out-of-network practitioner to receive Family Planning Services.~~

~~1. Behavioral Health Care: Behavioral Health Care Services shall be available to a Member, pursuant to CalOptima Policy CMC.6033: Behavioral Health Assessment, Referral, Coordination and Information Sharing for OneCare Connect Members.~~

~~B.~~D. ~~Provider Availability:~~Network Adequacy:

1. CalOptima and its Health Networks shall ~~meet CMS medical provider and facility, time and~~ contract with a sufficient number of providers and facilities to ensure that at least ninety percent (90%) of Members within the county can access care with specific travel/distance~~, and minimum number standards as annually updated~~ maximums.

   a. Standards can be found on the CMS website under 'Network Adequacy Standards' and the attachment to this Policy:

      i. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/

      ii. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html

~~1. CalOptima shall take into consideration the following provider types when evaluating adequate access to covered services:~~

~~a. High Volume Specialists:~~

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~~i. Identifying high-volume specialists annually: CalOptima shall identify high-volume specialists by assessing the volume of claims and encounters by specialty type in a previous calendar year. Specialties with the highest utilization shall be determined as a high-volume specialist. (Obstetrics/gynecology specialists shall be categorized as a PCP and a high-volume specialist, in accordance with industry standards.)~~

~~b.~~a. ~~High Impact Specialists:~~

~~i. Identifying high-impact specialists annually: CalOptima shall identify high-impact specialists by a) identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or b) identifying practitioner types where treatment requires significant resources.~~

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~~c. Behavioral Health Specialists:~~

~~i. High Volume Behavioral Health Provider: CalOptima identified the following provider types as high-volume behavioral health providers: psychologists, and licensed clinical social workers.~~

~~d.~~a. ~~Hospitals;~~

~~e.~~a. ~~Long Term Support Services (LTSS):~~

~~i. CalOptima shall contract with Long Term Care Facilities in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.~~

~~f.~~a. ~~Community-Based Adult Services (CBAS) Centers:~~

~~i. CalOptima shall ensure that every CBAS provider within the Service Area that has been approved by the California Department of Aging (CDA) as a CBAS provider as of July 1, 2012, is included in the provider network, to the extent that the CBAS provider remains licensed, certified, operating, and is willing to enter into a subcontract with CalOptima on mutually agreeable terms and meets CalOptima's credential and quality standards.~~

~~ii. If CalOptima determines that the additional CBAS providers are necessary to meet the needs of its Members, CalOptima may extend a contract to any CBAS provider certified by the CDA after July 1, 2012. CalOptima shall consider a Member's relationship with previous CBAS providers when ensuring access to CBAS. CalOptima shall not be required to include CBAS providers that were certified by the CDA after July 1, 2012 in the provider network.~~

~~iii.~~i. ~~If CalOptima has assessed a Member and determines that the Member is eligible for CBAS services and there is insufficient CBAS center capacity in the area, CalOptima may authorize unbundled services and facilitate utilization through care coordination in accordance with CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes.~~

~~2. CalOptima shall take into consideration the geographic location of Providers and Members accounting for distance, travel time, and mode of transportation when evaluating adequate access to Covered Services.~~

~~a. CalOptima shall take into consideration Members' and Practitioners' language and gender when evaluating adequate access to Covered Services.~~

~~3. CalOptima shall take into consideration the number of Providers who are not accepting new patients when evaluating adequate access to Covered Services.~~

~~4. CalOptima shall take into consideration the anticipated Member enrollment numbers when evaluating adequate access to Covered Services.~~

~~2. Telephone Access:~~

~~C.~~E. Telephone Triage or Screening Services:

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1. Telephone Triage or Screening Services shall be available twenty-four (24) hours a day, seven (7) days a week. Telephone Triage or Screening ~~waiting time~~Waiting Time shall not exceed thirty (30) minutes.

2. CalOptima or a Health Network may provide telephone Triage or Screening Services through:

   i. CalOptima or Health Network-operated telephone Triage and Screening Services;

   ii. A telephone medical advice service consistent with Section 1348.8 of the Health and Safety Code;

   iii. CalOptima or the Health Network's contracted Primary Care or Behavioral ~~health care~~Health Care provider office; or

   iv. Other method that provides Triage or Screening Services.

3. If CalOptima or a Health Network contracts with a primary care or mental health care Provider for the provision of telephone Triage or Screening Services, such Providers shall maintain a procedure for Triaging or Screening Member telephone calls twenty-four (24) hours a day, seven (7) days a week, with a telephone answering machine and/or answering service, and/or office staff, that informs the Member:

   i. Regarding the length of wait for a return call from the Provider; and

   ii. How the caller may obtain urgent or emergency care including, when applicable, how to contact another Provider who has agreed to be on-call, Triage, or Screen by phone, or, if needed, deliver urgent or emergency care.

4. An unlicensed staff member may perform Triage or Screening on behalf of a licensed staff member in order to assist in determining the Member's condition and refer the Member to a licensed staff member. Such unlicensed staff member shall not use this information obtained from Triage or Screening in an attempt to assess, evaluate, advise, or make any decision regarding the Member's condition, or determine when the Member should see a licensed Provider.

~~D.~~F. Telephone ~~wait time~~access during business hours:

1. CalOptima and its Health Networks shall operate a call center during normal business hours, as indicated in 42 CFR, Sections 422.111 and 423.128 and ensure:

   i. Eighty (80) percent of calls must be answered in thirty (30) seconds.

   ii. Average hold time must be limited to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system or pre-recorded greeting and before reaching a live person.

   iii. Limit the disconnect rate of all incoming calls to less than five (5) percent. A disconnected call is defined as a call that is unexpectantly dropped by the call center.

~~1.~~2. Telephone calls to answer: The total waiting time for a Member to reach a non-recorded voice at a Practitioners office shall not exceed thirty (30) seconds.

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~~2. The call abandonment rate for CalOptima or a Health Network shall not exceed five percent (5%).~~

3. Non-urgent and non-emergency messages during business hours: A Practitioner shall return the call within twenty-four (24) hours after the time of message.

4. Urgent message during business hours: A Practitioner shall return the call within thirty (30) minutes after the time of message.

5. Emergency message during business hours: All members shall be referred to the nearest emergency room. CalOptima shall have in its recorded message to include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

~~E.~~G. Telephone access after business hours:

1. After-hours access: A Primary Care Practitioner (PCP) or his or her designee, an appropriate licensed professional under his or her supervision, shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to after-hours Member calls or to a hospital emergency room Practitioner.

2. If live after-hours attendant answers and the call is an emergency, the attendant shall refer the Member to 911 ~~emergency services~~Emergency Services or instruct the Member to go to the nearest emergency room.

3. If a recorded message answers, it shall include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

~~F.~~H. Cultural and Linguistic Services shall be provided in accordance with CalOptima ~~policies~~Policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services:

~~1. Interpreter services:~~

1. Oral interpreter services shall be made available to a Member at no cost and in person, upon the Member's request, or by telephone at Key Points of Contact, twenty-four (24) hours a day, seven (7) days a week, in accordance with CalOptima Policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services.

2. Interpreter services shall be coordinated with scheduled appointments for health care services, whenever possible, to ensure the provision of interpreter services at the time of appointment.

3. Written Materials: All written materials shall be made available to Members in Threshold Languages, in accordance with CalOptima policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services.

4. Alternative Forms of Communication:

a. For a Member with a visual impairment, CalOptima and its Health Networks shall make informational or educational materials available at no cost in Threshold Languages in ~~at least sixteen (16)~~large print (no less than 20 point ~~size~~, Arial font~~,~~), audio format, or Braille, upon request or as needed within twenty-one (21) business days upon receipt of request or within a timely manner that is appropriate for the format requested~~.~~, in accordance with

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CalOptima policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services.

~~a.~~b. CalOptima and its Health Networks shall inform Members of the availability of these materials through the Member Handbook/EOC booklet and other mechanisms, including, but not limited to, posters and flyers distributed at sites where Members receive Covered Services and at Member orientation sessions.

~~b.~~c. ~~Telecommunication Device for the Deaf (TDD): TDD~~Teletypewriter (TTY): TTY shall be made available to a Member, upon request, at no cost to the Member.

~~a. For a Member with a disability, CalOptima and its Health Networks shall provide reasonable accommodations, which may require individualized assistance, to ensure effective communication, including auxiliary aids and services.~~

I. Care During A Federal Disaster or Other State or Public Health Emergency Declaration

1. In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, CalOptima shall:

a. Allow Members to maintain access to their Part A/B, supplemental Part C and Part D benefits consistent with 42 CFR 422.100(m) and 423.124(a).

b. Allow the benefits to be furnished at specified non-contracted facilities;

c. Waive, in full, requirements for gatekeeper referrals, where applicable;

d. Temporarily reduce plan-approved out-of-network cost sharing to in-network cost-sharing amounts;

e. Waive the 30-day notifications to Members as long as all the changes benefit the Member;

f. Ensure Members have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when Members cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy, and when such access is not routine;

g. Lift their "refill-too-soon" edits; and

i. CalOptima may consider extending the implementation of the "refill-to-soon" edits past the expiration of the declaration.

h. Allow an affected Member to obtain the maximum extended day supply, if requested and available at the time of refill.

III. PROCEDURE

A. CalOptima shall ~~analyze performance~~participate in the validation of ~~access and availability, against the standards~~network adequacy from the preceding twelve (12) months to comply with requirements set forth in ~~this Policy.~~42 CFR sections 438.68 and 438.14(b)(1).

~~1.~~ CalOptima shall annually conduct the following~~:~~

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B. as a means to collect network adequacy data for monitoring CalOptima's Provider ~~Access Survey (appointment availability and access during and after business hours);~~Network and health networks, when appropriate:

1. Timely Access Survey;

~~1.~~2. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys~~; and~~ and/or other Member experience surveys;

~~2.~~3. ~~Primary Care Provider (PCP) Satisfaction~~Behavioral Health Member Experience Survey~~.~~;

~~2. CalOptima shall monitor quarterly for the following:~~
4. Geographic Access Mapping; and

5. Facility Site Reviews (FSRs) data collected in accordance with CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall analyze performance of CalOptima's network adequacy at the plan Provider Network and Health Network, against the standards set forth in this Policy, when available and appropriate.

1. Grievances and appeals data;

2. ~~Availability (provider/member~~ Network Adequacy (Provider/Member ratio and ~~GeoAccess~~time/distance) report;

3. Encounter/claims data; ~~and~~

4. Potential Quality Issues (~~PQI).~~PQIs); and

~~3. CalOptima shall monitor CalOptima's and Health Networks' access and availability as follows:~~

~~a. Track and review access and availability, in accordance with this Policy;~~

5. ~~Monitor and analyze telephone~~Telephone wait times through ~~quarterly~~ reports from the call center~~;~~.

~~b. Monitor telephone access for call abandonment rates;~~

~~c. Monitor Behavioral Health reports on access and availability of contracted Behavioral Health providers;~~

~~d. Review quarterly reports on Grievances and Complaints related to~~ Access~~;~~

~~e. Review information obtained through Member and Provider surveys conducted on an annual basis related to Access;~~

~~f. Review and monitor Triage and Screening Services;~~

~~C.~~D. ~~Report access~~ and availability performance against the standards set forth in this ~~Policy~~policy shall be reported to the Member Experience Sub-Committee ~~on an annual basis;~~by the Access and Availability Workgroup Chair, or Designee, on a quarterly basis to:

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1. Analyze and report results ~~of audit and review activities~~ in order to:

    a. Prioritize opportunities for improvement identified from analyses.

    b. Implement interventions on at least one (1) area of opportunity (if applicable) for the following areas:

        i. Non-~~behavioral health care~~Behavioral Health Care services and;

        ii. Behavioral ~~health care~~Health Care services.

    c. Evaluate the effectiveness of interventions for improving access to non-behavioral and ~~behavioral health care~~Behavioral Health Care services.

2. CalOptima shall annually develop the following:

    a. Accessibility analysis (appointment availability and access during and after business hours) report;

    b. Availability analysis (~~provider/member~~Provider/Member ratio and GeoAccess) report;

~~D.~~E. CalOptima shall submit a complete and accurate Health Service Delivery (HSD) report/template that reflects the entire contracted ~~provider network~~Provider Network and all required supporting documentation to CMS as part of the Triennial Network Adequacy Review.

1. If CalOptima is unable to meet time and distance standards, CalOptima shall ~~allow Members to access Medi-Cal services out-of-network, if the services are not available in-network.~~:

    a. Allow Members to access services out-of-network, if the services are not available in-network.

2. Notify affected enrollees at least 30 days in advance of the effective date of applicable changes in rules to address the inadequate network.

~~E.~~F. CalOptima shall provide the Health Networks and the Member Experience Sub-Committee with access and availability reports of CalOptima and Health Networks' performance. These reports shall include CalOptima's assessment results against the access and availability standards as set forth in this Policy.

~~F.~~G. If the Member Experience Sub-~~committee~~Committee identifies deficiencies or non-compliance of standards or requirements set for in this policy, the Chair of the Member Experience Sub-Committee, or designee, may take the following steps:

1. Request that the Health Network submit a Quality Improvement Plan or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant, if applicable.

2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, respectively; and

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3. Report the deficiencies or non-compliance to the Audit and Oversight Committee (AOC) and Compliance Committee, as appropriate.

H. ~~A~~If a Health Network has been identified as having a deficient network component(s) and/or fails to meet network adequacy components:

1. CalOptima and the Health Network shall authorize services through out-of-network Providers where Members may utilize any Provider in or out of CalOptima's network regardless of Health Network affiliation.

2. The Health Network shall submit a Quality Improvement Plan or PDSA, if requested. ~~***If issued a Corrective***~~

~~1.~~3. The~~***Action Plan (CAP), the***~~ Health Network shall submit a CAP to ~~***CalOptima's Audit and Oversight Department, in accordance with CalOptima Policy HH.2002A: Corrective Action Plan***~~the CalOptima Office of Compliance, if necessary. A Health Network shall take all necessary and appropriate action to identify the causes underlying ~~***identified timely***~~ the access-related deficiencies, including but not limited to a review of whether Provider hours of operation and/or Providers' scheduling practices contributed to the deficiencies, and resolve such deficiencies, to comply with the standards of this Policy and CalOptima Policy HH.~~***2002A***~~2005Δ: Corrective Action Plan.

~~G.~~I. The Quality Analytics Department shall coordinate performance reviews to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

~~H.~~J. The Quality Analytics Department shall annually update CalOptima's Access and Availability desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

A. Network Adequacy Standards for OneCare and OneCare Connect

V. REFERENCE(S)

A. Age Discrimination Act of 1975
B. California Civil Code, Section 51
C. California Government Code, Section 11135
D. CalOptima Policy CMC.4002: Cultural and Linguistic Services
E. CalOptima Policy CMC.6030: Transition of Care
F. CalOptima Policy CMC.6031: Health Risk Assessment
G. CalOptima Policy CMC.6033: Behavioral Health ~~Assessment, Referral, Coordination and Information Sharing~~Services for OneCare Connect Members
H. CalOptima Policy EE.1135: Long Term Care Facility Contracting
I. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.
J. CalOptima Policy GG.1122: Follow-up for Emergency Department Care
K. CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
L. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Care Network Providers
M. CalOptima Policy GG.1508: Authorization and Processing of Referrals

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N. CalOptima Policy GG.1539 Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Policy GG.1619: Delegation Oversight
P. CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines
Q. CalOptima Policy HH.2002Δ: Sanctions
R. CalOptima Policy HH.2005Δ: Corrective Action Plan
S. CalOptima Policy MA.4002: Cultural and Linguistic Services
T. CalOptima Policy MA.6022: Initial and Annual Health Risk Assessment
U. CalOptima Policy MA.6030: Transition of Care
V. CalOptima Operational Audit Tool
W. CalOptima Quality Improvement Plan
X. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
Y. Department of Health Care Services (DHCS) Dual Plan Letter ~~13-002~~17-001: Health Risk Assessment and Risk Stratification Requirements for ~~Dual Demonstration Plans Under the Coordinated Care Initiatives~~Cal MediConnect
Z. National Committee of Quality Assurance (NCQA) standards
AA. OneCare Availability Standards: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/
BB. OneCare Connect Availability Standards: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html
CC. Title 28, California Code of Regulations (CCR), §§ 1300.51(H), 1300.67.2, 1300.67.2.2
DD. Title 28, Code of Federal Regulations (CFR), Part 36
EE. Title 29, United States Code (USC), §794 (Section 504 of the Rehabilitation Act of 1973)
FF. Title 42, United States Code (USC), §2000d
GG. Title 42, Code of Federal Regulations (CFR), § 422.116
~~GG.~~HH. Title 45, Code of Federal Regulations (CFR), Part 80, Part 84, and Part 91
~~HH.~~II. Title VI of the Civil rights Act of 1964
~~II.~~JJ. Title IX of the Education Amendments of 1973

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2007	MA.7007	Access and Availability Standards	OneCare
Revised	10/01/2008	MA.7007	Access and Availability Standards	OneCare

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Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2011	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2013	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2014	MA.7007	Access and Availability Standards	OneCare
Revised	07/01/2015	MA.7007	Access and Availability	OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	08/01/2016	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	08/01/2017	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	12/01/2017	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	11/01/2018	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	TBD	MA.7007	Access and Availability	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Ancillary Services that require appointments	Ancillary ~~services~~Services may include, but are not limited to, radiology, physical therapy, occupational therapy, speech therapy, phlebotomy, home health, etc.
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services.
~~Certified Nurse Practitioner~~Behavioral Health Care	~~A Certified Nurse Practitioner can provide a full range of primary, acute~~Evaluation and treatment of psychological and substance abuse disorders including specialty mental health ~~care~~ services~~, including~~. Specialty mental health services may include, but are not limited to ~~primary care~~, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult ~~health, neonatal~~residential treatment services, crisis residential services and psychiatric health~~, gerontology health, etc.~~ facilities services.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care and some Routine Care of woman.
Complaint	OneCare: Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. ~~A Complaint may include concerns about the operations of Providers or CalOptima such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, respect paid to Members, and claims regarding the right of a Member to receive services or receive payment for services previously rendered.~~ A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Continuity of Care	OneCare: Continuity of Care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 2. Coordinated use of Ancillary Services; 3. Appropriate discharge planning; and 4. Timely placement at different levels of care including hospital, skilled nursing and home health care. OneCare Connect: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.

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Term	Definition
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 Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Cultural and Linguistic (C&L) Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members; 3. Providing translations of informational materials in Threshold Languages, providing oral translation for other language upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Member to culturally and linguistically appropriate community services, as needed.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Those covered inpatient and outpatient services required that are (1) furnished by a physician qualified to furnish ~~emergency services~~Emergency Services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.
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)).

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Term	Definition
Grievance	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 ~~involving~~that constitutes an ~~Organization~~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~~, a Health Network's,~~ or ~~a~~ Provider's operations, activities, or behavior, regardless of ~~any request~~whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for ~~remedial action.~~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 the purposes of this policy, a~~A Physician Hospital Consortium (PHC), ~~Physician Medical Group (PMG)~~physician group under a shared risk contract~~, specialty health network~~, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. For purposes of this policy, a Health Network shall also include the CalOptima Community Network.
Health Risk Assessment (HRA)	A tool designed to identify potential critical health factors that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.
Key Points of Contact	Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
~~Mid-Level Practitioner~~ Mental Health (Non-Physician) Outpatient Services	~~A non-physician practitioner who has a professional license and certification. They include but are not limited to, a Registered Nurse Practitioner (RNP), Nurse Practitioner (NP), Certified Nurse Midwives (CNM), Physician Assistant (PA), Certified Nurse Anesthetist (CRNA), Optometrist, Acupuncturist, Licensed Clinical Social Workers (LCSW), or Chiropractor.~~ For purposes of this Policy, non-specialty mental health services for treatment of mild to moderate impairments provided by psychologists and licensed clinical social workers.

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Term	Definition
Primary Care ~~Provider~~Practitioner/Physician (PCP)	~~A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under the CalOptima program.~~A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Licensed Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD, a PCP may also be a Specialty Care Provider or clinic.
Prior Authorization	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.
Provider	OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, ~~Physician Medical Group~~physician group, or other person or institution who furnishes Covered Services.
~~Provider~~ Network	For purposes of this Policy, the providers with which an organization contracts or makes arrangements to furnish covered health care services to their members.
Routine Care	Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.
Routine Physical Exams	A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

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Term	Definition
Rural Health Clinic	An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.
Screening	The assessment of a Member's health concerns and symptoms via communication with a qualified health professional acting within his or her scope of practice and who is trained to screen a Member who may need care, for the purpose of determining the urgency of the Member's need for care.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
~~Skilled Nursing Facility (SNF)~~	~~A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.~~
Specialty Care Provider (SCP)	~~Refers to higher-level medical services that require a referral from a primary care provider. Physicians who provide specialty care undergo extensive training to "specialize" in a given area of medicine, for example, oncology, cardiology, etc.~~ Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Triage or Screening	The evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the Member's need for care.
~~Urgent Authorization~~Triage or Screening Services	~~"Urgent" is defined as when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function.~~Assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to perform Triage or Screening Services.
Triage or Screening Waiting Time	The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

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Policy:	MA.7007
Title:	**Access and Availability**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy establishes required access and availability standards, including Provider Network adequacy, for Members to obtain effective, appropriate, and timely access to care and describes the process which CalOptima shall use for monitoring network adequacy.

II. POLICY

A. General Access

1. CalOptima shall evaluate CalOptima's and it's Health Network's compliance with the standards outlined in this Policy. Unless otherwise stated, each access and availability standard outlined herein shall have a minimum performance threshold of eighty percent (80%).

2. CalOptima and its Health Networks shall not discriminate against Members or individuals who are eligible to enroll, on the basis of health status or need for health care services, race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental disability.

3. CalOptima and its Health Networks shall ensure access for disabled Members which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

    a. If a Provider cannot meet the minimum access standards for disabled Members, CalOptima and its Health Networks shall coordinate the referral to a Provider who does have the appropriate access standards.

4. CalOptima and its Health Networks shall ensure that Providers offer flexibility in scheduling Covered Services to accommodate the needs of Members with disabilities.

5. If a Provider has a moral or ethical objection to provide a Covered Service to a Member, CalOptima, or a Health Network, shall refer the Member to a different Provider.

6. If a Health Network refers a Member to a different Provider pursuant to Section II.A.8 of this Policy, CalOptima shall not incur any additional expense as a result of such referral.

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7. CalOptima shall refer Members to, or assist Members in locating, available and accessible contracted Providers in neighboring service areas or out-of-network providers for obtaining Covered Services in a timely manner appropriate for the Member's needs.

    a. Out-of-network providers shall be made available to Members if CalOptima and its Health Networks are unable to arrange for an in-person visit with a contracted Provider.

8. If Covered Services are unavailable to the Member within the Provider Network, CalOptima, or a Health Network, shall arrange for the provision of specialty services from Specialty Care Providers outside of the network in a timely manner and, in accordance with CalOptima policy GG.1508: Authorization and Processing of Referrals.

9. CalOptima and its Health Networks shall ensure that contracting Providers offer CalOptima Members hours of operation that are:

    a. Convenient to the population;

    b. No less than the hours of operation offered to commercial members or comparable to Medi-Cal Fee-For-Service, if the Provider services only Medi-Cal Members, where applicable; and

    c. Do not discriminate against Medicare Members.

10. Sensitive Services: Sensitive Services shall be available to a Member within the CalOptima Plan. A Member may self-refer to an out-of-network Provider to receive Sensitive Services, without Prior Authorization, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

11. Minor Consent Services: Minor Consent Services shall be available to a Member under the age of 18 in a confidential manner without parental consent, pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals.

12. Women Health Services: CalOptima shall ensure female Members have direct access to a women's health specialist within the network to Provider women's routine and preventive health services and such access may be in addition to the Member's Primary Care Practitioners (PCP).

13. Family Planning Services: Family Planning Services shall be available to a Member, pursuant to CalOptima Policy GG.1118: Family Planning Services, Out-of-Network and consistent with Title 42 CFR section 441.20. A Member may self-refer to any Qualified Family Planning Practitioner, including an out-of-network practitioner to receive Family Planning Services.

14. Behavioral Health Care: Behavioral Health Care Services for OneCare Connect Members shall be available to a Member, pursuant to CalOptima Policy CMC.6033: Behavioral Health Services for OneCare Connect Members.

B. Network Providers

1. CalOptima and its Health Networks must maintain an appropriate network of specific Provider types to ensure the CalOptima's network has the capacity to provide all Medically Necessary Covered Services for current and anticipated membership.

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2. CalOptima shall meet federal requirements for access to Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services.

    a. If FQHC and RHCs services are not available in the Provider Network, CalOptima shall authorize out-of-network services subject to the prevailing Medicare Advantage payment requirements for out-of-network services.

3. CalOptima shall permit Indian Members eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as a PCP if the Indian Care Provider has capacity to Provide such services regardless of whether the Indian Health Care Provider is in or out of network.

    a. CalOptima shall demonstrate that there are sufficient Indian Health Care Providers in the Provider Network to ensure timely access to care for Indian Members who are eligible to receive services, where applicable.

4. CalOptima shall develop and execute a Memorandum of Understanding (MOU) with County Social Services Agency responsible for In-Home Supportive Services (IHSS) that reflects an agreement between CalOptima and the County Social Services Agency.

5. Certified Nurse-Midwife and Certified Nurse Practitioner Services: If Certified Nurse-Midwife services, as described in CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines, CalOptima Direct, or Certified Nurse Practitioner services are not available to a Member; a Member may self-refer to an out-of-network Certified Nurse-Midwife or Certified Nurse Practitioner to receive such services.

6. CalOptima shall take into consideration the following Provider types when evaluating adequate access to Covered Services:

    a. Primary Care Practitioners (PCPs):

        i. OB/GYNs may, but are not required, to contract with CalOptima as a PCP, if desired.

        ii. Members may select an OB/GYN as their PCP, as long as the Provider agrees to serve as a PCP.

    b. High Volume Specialists:

        i. On an annual basis, CalOptima shall identify high-volume specialists by assessing the volume of claims and encounters by specialty type in a previous calendar year. Specialties with the highest utilization shall be determined as a high-volume specialist. (Obstetrics/gynecology specialists shall be categorized as a PCP and a high-volume specialist, in accordance with industry standards.)

    c. High Impact Specialists:

        i. On an annual basis, CalOptima shall identify high-impact specialists by a) identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or b) identifying practitioner types where treatment requires significant resources.

    d. Mental Health (Non-Physician) Outpatient Specialists:

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i. High Volume Mental Health Provider: The following provider types are considered High-Volume Mental Health (Non-Physician) Providers : psychologists and licensed clinical social workers.

e. Hospitals;

f. Pharmacies;

g. Long Term Support Services (LTSS):

i. CalOptima shall contract with Long Term Care Facilities in accordance with CalOptima Policy EE.1135: Long Term Care Facility Contracting.

h. Community-Based Adult Services (CBAS) Centers:

i. CalOptima shall ensure that every CBAS provider is within the Service Area approved by the California Department of Aging (CDA) as a CBAS provider as of July 1, 2012, is included in the Provider Network, to the extent that the CBAS provider remains licensed, certified, operating, and meets CalOptima's credential and quality standards.

ii. If CalOptima determines that additional CBAS providers are necessary to meet the needs of its Members, CalOptima may extend a contract to any CBAS provider certified by the CDA after July 1, 2012. CalOptima shall consider a Member's relationship with previous CBAS providers when ensuring access to CBAS. CBAS providers certified by the CDA after July 1, 2012 are not required to be included in the Provider Network.

iii. If CalOptima has assessed a Member and determines that the Member is eligible for CBAS services and there is insufficient CBAS center capacity in the area, CalOptima may authorize unbundled services and facilitate utilization through care coordination in accordance with CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes.

7. CalOptima shall take the following into consideration:

a. Geographic location of Providers and Members accounting for distance, travel time, and mode of transportation when evaluating adequate access to Covered Services.

b. Members' and Practitioners' language and gender when evaluating adequate access to Covered Services.

c. The number of Providers who are not accepting new patients when evaluating adequate access to Covered Services.

d. Anticipated Member enrollment numbers when evaluating adequate access to Covered Services.

e. Expected utilization of services, in light of characteristics and health care needs of CalOptima Members.

C. Timely Access

1. Emergency Services: Emergency Services shall be available immediately to a Member twenty-four (24) hours a day, seven (7) days a week.

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a. CalOptima and its Health Networks shall cover emergency medical services without Prior Authorization.

b. CalOptima and its Health Networks shall have a designated emergency service facility within the Service Area, providing care twenty-four (24) hours a day, seven (7) days a week. This designated emergency service facility will have one (1) or more physicians and one (1) nurse on duty in the facility at all times.

c. CalOptima and its Health Networks shall provide adequate follow-up care for those Members who have been screened in the Emergency Room, in accordance with CalOptima Policy GG.1122: Follow-up for Emergency Department Care.

d. CalOptima and its Health Networks shall ensure that a Provider is available twenty-four (24) hours a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care to coordinate the transfer of stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies MA.6030: Transition of Care and CMC.6030: Transition of Care.

2. CalOptima and its Health Networks shall ensure that Members have effective and appropriate access to Covered Services in a timely manner, in accordance with the standards of this Policy. CalOptima shall evaluate CalOptima's and Health Network's compliance with the appointment access standards against a minimum performance threshold of eighty percent (80%), unless otherwise indicated.

a. Urgent Care Services: Available within twenty-four (24) hours of the request for appointment

b. Primary Care Appointments:

PRIMARY CARE APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointment for services that DO NOT require Prior Authorization	Available within forty-eight (48) hours of the request for appointment	80%
Non-Urgent Primary Care (including Obstetrics/Gynecology Primary Care) Appointments	Available within ten (10) business days of request for appointment	80%
Routine Physical Exams and Health Assessments: Appointments for Routine Physical Exams and health assessments	Available within thirty (30) calendar days of request for appointment	80%

c. Specialty and Ancillary Care Appointments:

i. Monitoring of specialty care appointments shall, at minimum, include the monitoring of the following Specialty Care Providers: Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialist/Infectious Diseases, Nephrology,

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Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, Podiatry and Pulmonology.

ii. Monitoring of ancillary appointments shall, at minimum, include the monitoring of the following: physical therapists, mammography providers, and MRI providers.

SPECIALTY AND ANCILLARY APPOINTMENTS		
Description	**Standard**	**Minimum Performance Level**
Urgent appointment for services that DO NOT require Prior Authorization	Available within forty-eight (48) hours of the request for appointment	80%
Urgent appointments for services that DO require Prior Authorization	Available within ninety-six (96) hours of the request for appointment	80%
Non-Urgent Specialty Care (including Obstetrics/Gynecology Specialty Care) Appointments	Available within fifteen (15) business days of request for appointment	80%
First Prenatal Visit: Appointments for the first prenatal visit	Available within two (2) weeks of request for appointment	80%
Non-Urgent Ancillary Services: Appointments for non-urgent Ancillary Services for the diagnosis or treatment of illness, injury, or other health conditions	Available within fifteen (15) business days of request for appointment	80%

d. Mental Health Outpatient Service Appointments:

i. Mental Health Services (Non-Physician) Outpatient Practitioners: Psychologist and Licensed Clinical Social Worker.

ii. Mental Health Services Provider (Physician): Psychiatrist

ROUTINE BEHAVIORAL HEALTH SERVICES		
Description	**Standard**	**Minimum Performance Level**
Appointment for Routine Care with a Mental Health (Non-Physician) Outpatient Services Provider	Available to a Member within ten (10) business days after the date of the request	80%
Appointment for follow-up Routine Care with a Mental Health (Non-Physician) Outpatient Services Provider	Members have a follow-up visit with a Mental Health (Non-Physician) Outpatient Services Provider within twenty (20) calendar days of initial visit for a specific condition	80%
Appointment for follow-up Routine Care with a Mental Health (Physician) Outpatient Services Provider	Members have a follow-up visit with a Mental Health (Physician) Outpatient Services Provider within thirty (30) calendar days of initial visit for a specific condition	80%

e. Exceptions to Time Frames for Appointments

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i. The time frame to obtain an appointment for the services described in Sections II.C.2 of this Policy may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice, and consistent with professionally recognized standards of practice, has determined and documented in the Member's record that a longer waiting time will not have a detrimental impact on the Member's health.

ii. A Provider may offer an appointment for non-urgent Primary Care within the same or next business day from the time the Member requests the appointment, and advance scheduling of an appointment at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

iii. Preventive care services and periodic follow-up care for the services described in Sections II.C.2 of this Policy may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of their practice.

iv. Subsequent routine appointments: Appointments for subsequent routine appointments for prenatal visits shall be available to a Member and shall be scheduled in advance in accordance with American College of Obstetricians and Gynecologists (ACOG) guidelines. All Medically Necessary services for pregnant Members will be covered. The most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) will be utilized as the minimum measure of quality for perinatal services by CalOptima and its Health Networks.

v. Rescheduling of Appointments: When it is necessary for a Provider or a Member to reschedule an appointment, the Provider shall promptly reschedule the appointment in a manner appropriate to the Member's health care needs and that ensures Continuity of Care consistent with good professional practice.

3. Health Risk Assessment (HRA): Appointment for HRA shall be completed in accordance with CalOptima Policies MA.6022: Initial and Annual Health Risk Assessment and CMC.6031: Health Risk Assessment.

4. In-office wait times shall not exceed forty-five (45) minutes before a Member is seen by a Provider.

D. Network Adequacy:

1. CalOptima and its Health Networks shall contract with a sufficient number of providers and facilities to ensure that at least ninety percent (90%) of Members within the county can access care with specific travel/distance maximums.

a. Standards can be found on the CMS website under 'Network Adequacy Standards' and the attachment to this Policy:

i. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/

ii. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html

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E. Telephone Triage or Screening Services:

1. Telephone Triage or Screening Services shall be available twenty-four (24) hours a day, seven (7) days a week. Telephone Triage or Screening Waiting Time shall not exceed thirty (30) minutes.

2. CalOptima or a Health Network may provide telephone Triage or Screening Services through:

   i. CalOptima or Health Network-operated telephone Triage and Screening Services;

   ii. A telephone medical advice service consistent with Section 1348.8 of the Health and Safety Code;

   iii. CalOptima or the Health Network's contracted Primary Care or Behavioral Health Care provider office; or

   iv. Other method that provides Triage or Screening Services.

3. If CalOptima or a Health Network contracts with a primary care or mental health care Provider for the provision of telephone Triage or Screening Services, such Providers shall maintain a procedure for Triaging or Screening Member telephone calls twenty-four (24) hours a day, seven (7) days a week, with a telephone answering machine and/or answering service, and/or office staff, that informs the Member:

   i. Regarding the length of wait for a return call from the Provider; and

   ii. How the caller may obtain urgent or emergency care including, when applicable, how to contact another Provider who has agreed to be on-call, Triage, or Screen by phone, or, if needed, deliver urgent or emergency care.

4. An unlicensed staff member may perform Triage or Screening on behalf of a licensed staff member in order to assist in determining the Member's condition and refer the Member to a licensed staff member. Such unlicensed staff member shall not use this information obtained from Triage or Screening in an attempt to assess, evaluate, advise, or make any decision regarding the Member's condition, or determine when the Member should see a licensed Provider.

F. Telephone access during business hours:

1. CalOptima and its Health Networks shall operate a call center during normal business hours, as indicated in 42 CFR, Sections 422.111 and 423.128 and ensure:

   i. Eighty (80) percent of calls must be answered in thirty (30) seconds.

   ii. Average hold time must be limited to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system or pre-recorded greeting and before reaching a live person.

   iii. Limit the disconnect rate of all incoming calls to less than five (5) percent. A disconnected call is defined as a call that is unexpectantly dropped by the call center.

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2. Telephone calls to answer: The total waiting time for a Member to reach a non-recorded voice at a Practitioners office shall not exceed thirty (30) seconds.

3. Non-urgent and non-emergency messages during business hours: A Practitioner shall return the call within twenty-four (24) hours after the time of message.

4. Urgent message during business hours: A Practitioner shall return the call within thirty (30) minutes after the time of message.

5. Emergency message during business hours: All members shall be referred to the nearest emergency room. CalOptima shall have in its recorded message to include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

G. Telephone access after business hours:

1. After-hours access: A Primary Care Practitioner (PCP) or his or her designee, an appropriate licensed professional under his or her supervision, shall be available twenty-four (24) hours a day, seven (7) days a week, to respond to after-hours Member calls or to a hospital emergency room Practitioner.

2. If live after-hours attendant answers and the call is an emergency, the attendant shall refer the Member to 911 Emergency Services or instruct the Member to go to the nearest emergency room.

3. If a recorded message answers, it shall include the following: "If you feel that this is an emergency, hang up and dial nine-one-one (911) or go to the nearest emergency room."

H. Cultural and Linguistic Services shall be provided in accordance with CalOptima Policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services:

1. Oral interpreter services shall be made available to a Member at no cost and in person, upon the Member's request, or by telephone at Key Points of Contact, twenty-four (24) hours a day, seven (7) days a week, in accordance with CalOptima Policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services.

2. Interpreter services shall be coordinated with scheduled appointments for health care services, whenever possible, to ensure the provision of interpreter services at the time of appointment.

3. Written Materials: All written materials shall be made available to Members in Threshold Languages, in accordance with CalOptima policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services.

4. Alternative Forms of Communication:

a. For a Member with a visual impairment, CalOptima and its Health Networks shall make informational or educational materials available at no cost in Threshold Languages in large print (no less than 20 point, Arial font), audio format, or Braille, upon request or as needed within twenty-one (21) business days upon receipt of request or within a timely manner that is appropriate for the format requested, in accordance with CalOptima policies MA.4002: Cultural and Linguistic Services and CMC.4002: Cultural and Linguistic Services.

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b. CalOptima and its Health Networks shall inform Members of the availability of these materials through the Member Handbook/EOC booklet and other mechanisms, including, but not limited to, posters and flyers distributed at sites where Members receive Covered Services and at Member orientation sessions.

c. Teletypewriter (TTY): TTY shall be made available to a Member, upon request, at no cost to the Member.

I. Care During A Federal Disaster or Other State or Public Health Emergency Declaration

1. In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, CalOptima shall:

a. Allow Members to maintain access to their Part A/B, supplemental Part C and Part D benefits consistent with 42 CFR 422.100(m) and 423.124(a).

b. Allow the benefits to be furnished at specified non-contracted facilities;

c. Waive, in full, requirements for gatekeeper referrals, where applicable;

d. Temporarily reduce plan-approved out-of-network cost sharing to in-network cost-sharing amounts;

e. Waive the 30-day notifications to Members as long as all the changes benefit the Member;

f. Ensure Members have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when Members cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy, and when such access is not routine;

g. Lift their "refill-too-soon" edits; and

i. CalOptima may consider extending the implementation of the "refill-to-soon" edits past the expiration of the declaration.

h. Allow an affected Member to obtain the maximum extended day supply, if requested and available at the time of refill.

III. PROCEDURE

A. CalOptima shall participate in the validation of network adequacy from the preceding twelve (12) months to comply with requirements set forth in 42 CFR sections 438.68 and 438.14(b)(1).

B. CalOptima shall annually conduct the following as a means to collect network adequacy data for monitoring CalOptima's Provider Network and health networks, when appropriate:

1. Timely Access Survey;

2. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and/or other Member experience surveys;

3. Behavioral Health Member Experience Survey;

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4. Geographic Access Mapping; and

5. Facility Site Reviews (FSRs) data collected in accordance with CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall analyze performance of CalOptima's network adequacy at the plan Provider Network and Health Network, against the standards set forth in this Policy, when available and appropriate.

1. Grievances and appeals data;

2. Network Adequacy (Provider/Member ratio and time/distance) report;

3. Encounter/claims data;

4. Potential Quality Issues (PQIs); and

5. Telephone wait times through reports from the call center.

D. Access and availability performance against the standards set forth in this policy shall be reported to the Member Experience Sub-Committee by the Access and Availability Workgroup Chair, or Designee, on a quarterly basis to:

1. Analyze and report results in order to:

a. Prioritize opportunities for improvement identified from analyses.

b. Implement interventions on at least one (1) area of opportunity (if applicable) for the following areas:

i. Non-Behavioral Health Care services and;

ii. Behavioral Health Care services.

c. Evaluate the effectiveness of interventions for improving access to non-behavioral and Behavioral Health Care services.

2. CalOptima shall annually develop the following:

a. Accessibility analysis (appointment availability and access during and after business hours) report;

b. Availability analysis (Provider/Member ratio and GeoAccess) report;

E. CalOptima shall submit a complete and accurate Health Service Delivery (HSD) report/template that reflects the entire contracted Provider Network and all required supporting documentation to CMS as part of the Triennial Network Adequacy Review.

1. If CalOptima is unable to meet time and distance standards, CalOptima shall:

a. Allow Members to access services out-of-network, if the services are not available in-network.

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2. Notify affected enrollees at least 30 days in advance of the effective date of applicable changes in rules to address the inadequate network.

F. CalOptima shall provide the Health Networks and the Member Experience Sub-Committee with access and availability reports of CalOptima and Health Networks' performance. These reports shall include CalOptima's assessment results against the access and availability standards as set forth in this Policy.

G. If the Member Experience Sub-Committee identifies deficiencies or non-compliance of standards or requirements set for in this policy, the Chair of the Member Experience Sub-Committee, or designee, may take the following steps:

1. Request that the Health Network submit a Quality Improvement Plan or Plan-Do-Study-Act (PDSA) cycle(s) for performance measures that are deemed deficient or non-compliant, if applicable.

2. Submit a Request for Compliance Action (RCA) to the Office of Compliance to request corrective action. Such corrective action may include the issuance of a request for a Corrective Action Plan (CAP) and/or the imposition of Sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions, respectively; and

3. Report the deficiencies or non-compliance to the Audit and Oversight Committee (AOC) and Compliance Committee, as appropriate.

H. If a Health Network has been identified as having a deficient network component(s) and/or fails to meet network adequacy components:

1. CalOptima and the Health Network shall authorize services through out-of-network Providers where Members may utilize any Provider in or out of CalOptima's network regardless of Health Network affiliation.

2. The Health Network shall submit a Quality Improvement Plan or PDSA, if requested.

3. The Health Network shall submit a CAP to the CalOptima Office of Compliance, if necessary. A Health Network shall take all necessary and appropriate action to identify the causes underlying the access-related deficiencies, including but not limited to a review of whether Provider hours of operation and/or Providers' scheduling practices contributed to the deficiencies, and resolve such deficiencies, to comply with the standards of this Policy and CalOptima Policy HH.2005Δ: Corrective Action Plan.

I. The Quality Analytics Department shall coordinate performance reviews to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

J. The Quality Analytics Department shall annually update CalOptima's Access and Availability desktop procedures to assess adherence to access and availability standards, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

A. Network Adequacy Standards for OneCare and OneCare Connect

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V. REFERENCE(S)

A. Age Discrimination Act of 1975
B. California Civil Code, Section 51
C. California Government Code, Section 11135
D. CalOptima Policy CMC.4002: Cultural and Linguistic Services
E. CalOptima Policy CMC.6030: Transition of Care
F. CalOptima Policy CMC.6031: Health Risk Assessment
G. CalOptima Policy CMC.6033: Behavioral Health Services for OneCare Connect Members
H. CalOptima Policy EE.1135: Long Term Care Facility Contracting
I. CalOptima Policy GG.1118: Family Planning Services, Out-of-Network.
J. CalOptima Policy GG.1122: Follow-up for Emergency Department Care
K. CalOptima Policy GG.1130: Community-Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
L. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Care Network Providers
M. CalOptima Policy GG.1508: Authorization and Processing of Referrals
N. CalOptima Policy GG.1539 Authorization for Out-of-Network and Out-of-Area Services
O. CalOptima Policy GG.1619: Delegation Oversight
P. CalOptima Policy GG.1713: Nurse-Midwife Practice Guidelines
Q. CalOptima Policy HH.2002Δ: Sanctions
R. CalOptima Policy HH.2005Δ: Corrective Action Plan
S. CalOptima Policy MA.4002: Cultural and Linguistic Services
T. CalOptima Policy MA.6022: Initial and Annual Health Risk Assessment
U. CalOptima Policy MA.6030: Transition of Care
V. CalOptima Operational Audit Tool
W. CalOptima Quality Improvement Plan
X. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
Y. Department of Health Care Services (DHCS) Dual Plan Letter 17-001: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
Z. National Committee of Quality Assurance (NCQA) standards
AA. OneCare Availability Standards: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApps/
BB. OneCare Connect Availability Standards: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html
CC. Title 28, California Code of Regulations (CCR), §§ 1300.51(H), 1300.67.2, 1300.67.2.2
DD. Title 28, Code of Federal Regulations (CFR), Part 36
EE. Title 29, United States Code (USC), §794 (Section 504 of the Rehabilitation Act of 1973)
FF. Title 42, United States Code (USC), §2000d
GG. Title 42, Code of Federal Regulations (CFR), § 422.116
HH. Title 45, Code of Federal Regulations (CFR), Part 80, Part 84, and Part 91
II. Title VI of the Civil rights Act of 1964
JJ. Title IX of the Education Amendments of 1973

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

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VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2007	MA.7007	Access and Availability Standards	OneCare
Revised	10/01/2008	MA.7007	Access and Availability Standards	OneCare
Revised	07/01/2011	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2013	MA.7007	Access and Availability Standards	OneCare
Revised	01/01/2014	MA.7007	Access and Availability Standards	OneCare
Revised	07/01/2015	MA.7007	Access and Availability	OneCare OneCare Connect
Non-Substantive Edit	05/10/2016	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	08/01/2016	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	08/01/2017	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	12/01/2017	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	11/01/2018	MA.7007	Access and Availability	OneCare OneCare Connect
Revised	TBD	MA.7007	Access and Availability	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Ancillary Services that require appointments	Ancillary Services may include, but are not limited to, radiology, physical therapy, occupational therapy, speech therapy, phlebotomy, home health, etc.
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders including specialty mental health services. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some Routine Care of woman.
Complaint	OneCare: Any expression of dissatisfaction to CalOptima, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Continuity of Care	OneCare: Continuity of Care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 2. Coordinated use of Ancillary Services; 3. Appropriate discharge planning; and 4. Timely placement at different levels of care including hospital, skilled nursing and home health care. OneCare Connect: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
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 Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).

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Term	Definition
Cultural and Linguistic (C&L) Services	Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to: 1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs; 2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members; 3. Providing translations of informational materials in Threshold Languages, providing oral translation for other language upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and 4. Referring Member to culturally and linguistically appropriate community services, as needed.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Those covered inpatient and outpatient services required that are (1) furnished by a physician qualified to furnish Emergency Services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.
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)).
Grievance	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	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network. For purposes of this policy, a Health Network shall also include the CalOptima Community Network.

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Term	Definition
Health Risk Assessment (HRA)	A tool designed to identify potential critical health factors that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.
Key Points of Contact	Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.
Member	A beneficiary enrolled in a CalOptima program.
Mental Health (Non-Physician) Outpatient Services	For purposes of this Policy, non-specialty mental health services for treatment of mild to moderate impairments provided by psychologists and licensed clinical social workers.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (e.g., Nurse Practitioner [NP], Nurse Midwife, Licensed Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD, a PCP may also be a Specialty Care Provider or clinic.
Prior Authorization	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.
Provider	OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Provider Network	For purposes of this Policy, the providers with which an organization contracts or makes arrangements to furnish covered health care services to their members.
Routine Care	Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.

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Term	Definition
Routine Physical Exams	A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.
Rural Health Clinic	An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.
Screening	The assessment of a Member's health concerns and symptoms via communication with a qualified health professional acting within his or her scope of practice and who is trained to screen a Member who may need care, for the purpose of determining the urgency of the Member's need for care.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialty Care Provider (SCP)	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Triage or Screening	The evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the Member's need for care.
Triage or Screening Services	Assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to perform Triage or Screening Services.
Triage or Screening Waiting Time	The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

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OneCare Network Adequacy

Adequacy Standards

Provider Specialty/Type	Provider Ratios	Minimum # Providers	Pct of Access	Distance (miles)	Time (minutes)
Specialists					
Primary Care	1.67	72	90%	5	10
Allergy and Immunology	0.05	3	90%	15	30
Cardiology	0.27	12	90%	10	20
Cardiothoracic Surgery	0.01	1	90%	15	30
Chiropractor	0.10	5	90%	15	30
Dermatology	0.16	7	90%	10	20
Endocrinology	0.04	2	90%	15	30
ENT/Otolaryngology	0.06	3	90%	15	30
Gastroenterology	0.12	6	90%	10	20
General Surgery	0.28	13	90%	10	20
Gynecology, OB/GYN	0.04	2	90%	15	30
Infectious Diseases	0.03	2	90%	15	30
Nephrology	0.09	4	90%	15	30
Neurology	0.12	6	90%	10	20
Neurosurgery	0.01	1	90%	15	30
Oncology - Medical, Surgical	0.19	9	90%	10	20
Oncology - Radiation/Radiation Oncology	0.06	3	90%	15	30
Ophthalmology	0.24	11	90%	10	20
Orthopedic Surgery	0.20	9	90%	10	20
Physiatry, Rehabilitative Medicine	0.04	2	90%	15	30
Plastic Surgery	0.01	1	90%	15	30
Podiatry	0.19	9	90%	10	20
Psychiatry	0.14	7	90%	10	20
Pulmonology	0.13	6	90%	10	20
Rheumatology	0.07	4	90%	15	30
Urology	0.12	6	90%	10	20
Vascular Surgery	0.02	1	90%	15	30

Facility Type	Provider Ratios	Minimum # Providers	Pct of Access	Distance (miles)	Time (minutes)
Facilities					
Acute Inpatient Hospitals	12.20	525	90%	20	10
Cardiac Surgery Program	NA	1	90%	30	15
Cardiac Catheterization Services	NA	1	90%	30	15
Critical Care Services – Intensive Care Units (ICU)	NA	1	90%	20	10
Surgical Services (Outpatient or ASC)	NA	1	90%	20	10
Skilled Nursing Facilities	NA	1	90%	20	10
Diagnostic Radiology	NA	1	90%	20	10
Mammography	NA	1	90%	20	10
Physical Therapy	NA	1	90%	20	10
Occupational Therapy	NA	1	90%	20	10
Speech Therapy	NA	1	90%	20	10
Inpatient Psychiatric Facility Services	NA	1	90%	30	15
Outpatient Infusion/Chemotherapy	NA	1	90%	20	10

* For CalOptima, the minimum ratio for provider specialty types represents the minimum number of providers per 1,000 beneficiaries.

**For the Health Networks, the minimum ratio for provider specialty types represents the minimum number of providers per 1,000 HN members in the program.

***Standards are based on Centers for Medicare and Medicaid Services (CMS) Annual Health Service Delivery (HSD) Criteria Reference Tables (updated annually at the beginning of each year)

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OneCare Connect Network Adequacy

Adequacy Standards

Provider Specialty Type	Provider Ratios	Minimum # Providers	Pct of Access	Distance (miles)	Time (minutes)
Specialists					
Primary Care	1.29	26	90%	5	10
Allergy and Immunology	0.05	1	90%	15	30
Cardiology	0.11	3	90%	10	20
Cardiothoracic Surgery	0.01	1	90%	15	30
Chiropractor	0.01	1	90%	15	30
Dermatology	0.04	1	90%	10	20
Endocrinology	0.02	1	90%	15	30
ENT/Otolaryngology	0.03	1	90%	15	30
Gastroenterology	0.09	2	90%	10	20
General Surgery	0.16	4	90%	10	20
Gynecology, OB/GYN	0.03	1	90%	15	30
Infectious Diseases	0.02	1	90%	15	30
Nephrology	0.10	2	90%	15	30
Neurology	0.10	2	90%	10	20
Neurosurgery	0.01	1	90%	15	30
Oncology - Medical, Surgical	0.08	2	90%	10	20
Oncology - Radiation/Radiation Oncology	0.03	1	90%	15	30
Ophthalmology	0.12	3	90%	10	20
Orthopedic Surgery	0.09	2	90%	10	20
Physiatry, Rehabilitative Medicine	0.06	2	90%	15	30
Plastic Surgery	0.01	1	90%	15	30
Podiatry	0.12	3	90%	10	20
Psychiatry	0.16	4	90%	10	20
Pulmonology	0.08	2	90%	10	20
Rheumatology	0.03	1	90%	15	30
Urology	0.05	1	90%	10	20
Vascular Surgery	0.01	1	90%	15	30

Facility Type	Provider Ratios	Minimum # Providers	Pct of Access	Distance (miles)	Time (minutes)
Facilities					
Acute Inpatient Hospitals	12.00	236	90%	10	20
Cardiac Surgery Program	NA	1	90%	15	30
Cardiac Catheterization Services	NA	1	90%	15	30
Critical Care Services – Intensive Care Units	NA	1	90%	10	20
Surgical Services (Outpatient or ASC)	NA	1	90%	10	20
Skilled Nursing Facilities	NA	1	90%	10	20
Diagnostic Radiology	NA	1	90%	10	20
Mammography	NA	1	90%	10	20
Physical Therapy	NA	1	90%	10	20
Occupational Therapy	NA	1	90%	10	20
Speech Therapy	NA	1	90%	10	20
Inpatient Psychiatric Facility Services	NA	1	90%	15	30
Outpatient Infusion/Chemotherapy	NA	1	90%	10	20

*For CalOptima, the minimum ratio for provider specialty types represents the minimum number of providers per 1,000 beneficiaries.

**For the Health Networks, the minimum ratio for provider specialty types represents the minimum number of providers per 1,000 HN members in the program.

***Standards are based on Centers for Medicare and Medicaid Services (CMS) Annual Health Service Delivery (HSD) Criteria Reference Tables (updated annually at the beginning of each year)

For 20220505 BOD Review Only

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Summary of changes to Policy MA.7007: Access and Availability

Below is a list of substantive changes to the policy, which are reflected in the attached redline. 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 Section	Change and Rationale
Page 1; Section II.A.1; Page 5; Section II.C.2; Page 7; Section II.C.2.d.ii	Changed minimum performance threshold to 80% in align with policy, GG.1600 Medi-Cal Access and Availability and the industry standard.
Page 2; Section II.A.7	Updated language on CalOptima's role in assisting members in locating Out of Networks providers per OCC 3-Way Contract
Page 2; Section II.A.9.	Added language that hours of operation must be convenient, no less that commercial or Medi-Cal Fee-For-Service, if only for Medi-Cal members, and do not discriminate per OCC 3-Way Contract
Page 2; Section II.A.11	Added language that Minor Consent Services shall be available to members under at of 18, as indicated in policy GG.1508 Authorization and Processing of Referrals
Page 2; Section II.A.12	Added language that female members shall have direct access to women's health specialist within the network per OCC 3-Way Contract
Page 3; Section II.B.2-3	Added network requirements for members to access FQHCs and Rural Health Clinics (RHCs), and Indian Health Care Provider per OCC 3-Way Contract
Page 3; Section II.B.4	Added requirements to execute MOU with county SSA for In-Home Support Services per OCC 3-Way Contract
Page 3; Section II.B.6ai	Clarified OB/GYNs ability to contract as PCPC and members' ability to select them
Page 4; Section II.B.7e	Added language that evaluation of member access includes expected utilization
Page 6; Section II.C.2.c.ii	Added the following standards: Urgent appointment for services that do not require prior authorization
Page 11; Section II.F.1	Updated call center standards phone wait time standards: 80% of calls must be answered in 30 seconds, average hold time limited to 2 minutes, and disconnect rate less than 5 minutes per Final Rule (Sections 422.111 and 423.128)
Page 12; Section II.H.4.a	Updated Font size to 20 for information and educational materials per MA.4002: Cultural and Linguistic Services
Page 13; Section II.I	Added language on care to be provided during a federal disaster or other state or public health emergency declaration per CMS Final Rule Part C & D
Page 13; Section III.A	Added language of CalOptima's participation in the validation of Network Adequacy
Page 13-15; Section III.B-D	Updated the language to reflect the current process of monitoring access
Page 14; Section III.D	Add language that access performance will be reported to Member Experience Committee by the Timely Access Workgroup Chair or designee
Page 15; Section III.E	Add language that CalOptima must notify enrollees as least 30 days in advance of applicable changes in rules to address, if there's an inadequate network
Pages 16-17; Pages 19-23; Section IX	Updated references and definitions in glossary, as needed

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Financial Summary

March 31, 2022

Board of Directors Meeting

May 5, 2022

Nancy Huang, Chief Financial Officer

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Financial Highlights: March 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
886,480	839,216	47,264	5.6%	Member Months	7,803,093	7,576,567	226,526	3.0%
474,145,493	278,619,869	195,525,624	70.2%	Revenues	3,384,009,612	2,825,166,821	558,842,791	19.8%
438,035,044	273,909,120	(164,125,924)	(59.9%)	Medical Expenses	3,117,818,796	2,752,731,329	(365,087,467)	(13.3%)
12,147,211	15,607,216	3,460,005	22.2%	Administrative Expenses	109,300,183	133,089,676	23,789,493	17.9%
23,963,238	**(10,896,467)**	**34,859,705**	**319.9%**	**Operating Margin**	**156,890,633**	**(60,654,184)**	**217,544,817**	**358.7%**
(7,155,705)	833,334	(7,989,039)	(958.7%)	Non Operating Income (Loss)	(16,379,153)	7,500,000	(23,879,153)	(318.4%)
16,807,533	**(10,063,133)**	**26,870,666**	**267.0%**	**Change in Net Assets**	**140,511,480**	**(53,154,184)**	**193,665,664**	**364.3%**
92.4%	98.3%	5.9%		Medical Loss Ratio	92.1%	97.4%	5.3%	
2.6%	5.6%	3.0%		Administrative Loss Ratio	3.2%	4.7%	1.5%	
5.1%	(3.9%)	9.0%		Operating Margin Ratio	4.6%	(2.1%)	6.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.2%	98.3%	9.1%		*MLR (excluding Directed Payments)	91.4%	97.4%	6.0%	
3.6%	5.6%	2.0%		*ALR (excluding Directed Payments)	3.5%	4.7%	1.2%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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Consolidated Performance: March 2022 (in millions)

February				July-February		
Actual	Budget	Variance		Actual	Budget	Variance
27.4	(10.1)	37.5	Medi-Cal	148.9	(57.3)	206.1
(3.0)	(0.7)	(2.3)	OCC	6.4	(3.7)	10.0
(0.9)	(0.1)	(0.8)	OneCare	(1.7)	(0.9)	(0.8)
0.4	0.0	0.4	PACE	3.3	1.2	2.1
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.0)	0.0
24.0	**(10.9)**	**34.9**	**Operating**	**156.9**	**(60.7)**	**217.5**
(7.2)	0.8	(8.0)	Inv./Rental Inc, MCO tax	(16.4)	7.5	(23.9)
(7.2)	**0.8**	**(8.0)**	**Non-Operating**	**(16.4)**	**7.5**	**(23.9)**
16.8	**(10.1)**	**26.9**	**TOTAL**	**140.5**	**(53.2)**	**193.7**

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (Mar 2022): $16.8 million, favorable to budget $26.9 million or 267.0%, primarily due to higher than anticipated Calendar Year (CY) 2022 Medi-Cal rates and deferred and delayed services
  - YTD (Jul 2021 – Mar 2022): $140.5 million, favorable to budget $193.7 million or 364.3%
- Enrollment
  - MTD: 886,480 members, favorable to budget 47,264 or 5.6%
  - YTD: 7,803,093 members, favorable to budget 226,526 or 3.0%
- Revenue
  - MTD: $474.1 million, favorable to budget $195.5 million or 70.2% driven by Medi-Cal (MC) line of business (LOB):
    - $138.9 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP)
    - $49.3 million due to CY 2022 rate update and favorable enrollment
  - YTD: $3.4 billion, favorable to budget $558.8 million or 19.8% driven by MC LOB:
    - $271.5 million of FY 2020 hospital DP
    - $258.6 million due to CY 2022 rate update, favorable enrollment, prior year retroactive eligibility changes, and Proposition 56 estimates
    - $52.2 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 $31.0 million due to COVID-19 risk corridor

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $438.0 million, unfavorable to budget $164.1 million or 59.9% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $138.9 million due to FY 2020 hospital DP
    - Provider Capitation expense unfavorable variance of $18.8 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
  - YTD: $3.1 billion, unfavorable to budget $365.1 million or 13.3% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $277.7 million due to FY 2020 hospital DP
    - Provider Capitation expense unfavorable variance of $139.3 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Offset by net favorable variance from all other expenses of $47.9 million

FY 2021–22: Management Summary (cont.)

- Administrative Expenses
  - MTD: $12.1 million, favorable to budget $3.5 million or 22.2%
  - YTD: $109.3 million, favorable to budget $23.8 million or 17.9%
- Non-Operating Income (Loss)
  - MTD: ($7.2) million, unfavorable to budget $8.0 million or 958.7%
    - Unfavorable variance is primarily due to unrealized losses in treasuries and corporate bonds from the Federal Reserve's responses to inflation and continued increases to interest rates
  - YTD: ($16.4) million, unfavorable to budget $23.9 million or 318.4%

FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 92.4%, (89.2% excluding DP),Budget 98.3%
  - YTD: Actual 92.1% (91.4% excluding DP), Budget 97.4%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 2.6%, (3.6% excluding DP), Budget 5.6%
  - YTD: Actual 3.2% (3.5% excluding DP), Budget 4.7%
- Balance Sheet Ratios
  - *Current ratio: 1.68
  - Board-designated reserve funds level: 1.67
  - Net position: $1.4 billion, including required Tangible Net Equity (TNE) of $106.0 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: March 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
120,055	117,722	2,333	2.0%	SPD	1,071,006	1,055,764	15,242	1.4%
302,224	294,326	7,898	2.7%	TANF Child	2,705,268	2,667,218	38,050	1.4%
118,077	106,314	11,763	11.1%	TANF Adult	1,019,810	960,805	59,005	6.1%
3,172	3,191	(19)	(0.6%)	LTC	28,200	28,719	(519)	(1.8%)
313,081	289,115	23,966	8.3%	MCE	2,715,463	2,607,996	107,467	4.1%
12,410	11,159	1,251	11.2%	WCM	106,506	100,431	6,075	6.0%
869,019	**821,827**	**47,192**	**5.7%**	**Medi-Cal Total**	**7,646,253**	**7,420,933**	**225,320**	**3.0%**
14,587	**15,175**	**(588)**	**(3.9%)**	**OneCare Connect**	**132,819**	**135,991**	**(3,172)**	**(2.3%)**
2,461	**1,792**	**669**	**37.3%**	**OneCare**	**20,292**	**15,992**	**4,300**	**26.9%**
413	**422**	**(9)**	**(2.1%)**	**PACE**	**3,729**	**3,651**	**78**	**2.1%**
459	**625**	**(166)**	**(26.6%)**	**MSSP**	**1,368**	**1,535**	**(167)**	**(10.9%)**
886,480	**839,216**	**47,264**	**5.6%**	**CalOptima Total***	**7,803,093**	**7,576,567**	**226,526**	**3.0%**

*Note: CalOptima Total does not include MSSP

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Consolidated Revenue & Expenses: March 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	543,528	313,081	12,410	869,019	14,587	2,461	413	459	886,480
REVENUES									
Capitation Revenue	218,386,664	$ 182,797,912	$ 39,654,941	$ 440,839,516	$ 26,703,543	$ 2,939,367	$ 3,454,052	$ 209,015	$ 474,145,493
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	218,386,664	182,797,912	39,654,941	440,839,516	26,703,543	2,939,367	3,454,052	209,015	474,145,493
MEDICAL EXPENSES									
Provider Capitation	47,582,030	50,596,736	7,892,558	106,071,325	10,520,456	837,702			117,429,483
Facilities	25,799,604	26,163,358	8,525,272	60,488,234	5,078,647	1,154,656	768,551		67,490,088
Professional Claims	23,923,939	13,915,614	1,407,295	39,246,849	1,307,055	122,887	740,703		41,417,494
Prescription Drugs	141,482	(808,598)	744	(666,372)	8,294,393	1,335,502	357,959		9,321,482
MLTSS	43,076,433	4,597,564	1,689,836	49,363,832	1,484,304	135,869	10,302	37,165	51,031,472
Medical Management	2,569,678	1,620,724	343,411	4,533,813	1,103,020	32,258	874,047	103,613	6,646,751
Quality Incentives	1,183,918	803,567	30,335	2,017,820	214,065		(79,197)		2,152,688
Reinsurance & Other	77,951,626	54,449,187	9,809,093	142,209,905	200,275	5,525	129,880		142,545,585
Total Medical Expenses	222,228,710	151,338,152	29,698,544	403,265,406	28,202,216	3,624,398	2,802,245	140,778	438,035,044
Medical Loss Ratio	101.8%	82.8%	74.9%	91.5%	105.6%	123.3%	81.1%	67.4%	92.4%
GROSS MARGIN	**(3,842,046)**	**31,459,760**	**9,956,396**	**37,574,110**	**(1,498,673)**	**(685,032)**	**651,807**	**68,237**	**36,110,449**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				6,788,705	595,174	82,161	92,840	57,275	7,616,155
Professional fees				254,155	(16,241)	29,107		2,207	269,227
Purchased services				1,200,823	114,340	13,117	63,988		1,392,267
Printing & Postage				126,216	39,119	13,394	27,776		206,504
Depreciation & Amortization				342,626			370		342,995
Other expenses				1,961,665	1,225		14,049	3,891	1,980,830
Indirect cost allocation & Occupancy				(533,170)	783,681	69,669	13,550	5,502	339,233
Total Administrative Expenses				10,141,019	1,517,297	207,447	212,572	68,875	12,147,211
Admin Loss Ratio				2.3%	5.7%	7.1%	6.2%	33.0%	2.6%
INCOME (LOSS) FROM OPERATIONS				27,433,091	(3,015,971)	(892,479)	439,235	(638)	23,963,238
INVESTMENT INCOME									(8,201,907)
TOTAL MCO TAX				1,076,505					1,076,505
TOTAL GRANT INCOME				(30,303)					(30,303)
CHANGE IN NET ASSETS				**$ 28,479,293**	**$ (3,015,971)**	**$ (892,479)**	**$ 439,235**	**$ (638)**	**$ 16,807,533**
BUDGETED CHANGE IN NET ASSETS				(10,092,623)	(730,167)	(84,408)	29,243	(18,512)	(10,063,133)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 38,571,916	$ (2,285,804)	$ (808,071)	$ 409,992	$ 17,874	$ 26,870,666

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Consolidated Revenue & Expenses: March 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	4,824,284	2,715,463	106,506	7,646,253	132,819	20,292	3,729	1,368	7,803,093
REVENUES									
Capitation Revenue	1,569,179,962	$ 1,281,645,370	$ 227,807,665	3,078,632,998	$ 248,718,282	$ 25,698,424	$ 30,339,728	620,181	$ 3,384,009,612
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,569,179,962	1,281,645,370	227,807,665	3,078,632,998	248,718,282	25,698,424	30,339,728	620,181	3,384,009,612
MEDICAL EXPENSES									
Provider Capitation	412,278,933	445,618,677	81,138,304	939,035,915	98,883,147	7,083,374		-	1,045,002,435
Facilities	227,070,072	227,249,057	50,765,148	505,084,278	37,101,228	8,145,803	6,553,179	-	556,884,488
Professional Claims	195,736,381	101,667,874	12,766,566	310,170,820	10,050,586	938,327	7,119,620	-	328,279,354
Prescription Drugs	128,614,146	175,306,528	40,503,899	344,424,574	56,950,664	8,632,130	2,923,153	-	412,930,520
MLTSS	331,526,775	36,201,630	15,950,336	383,678,741	12,992,965	524,312	369,269	91,938	397,657,225
Medical Management	22,657,759	13,657,361	2,924,647	39,239,767	9,302,505	327,746	7,490,492	334,621	56,695,131
Quality Incentives	14,789,741	8,476,044	593,513	23,859,298	2,002,815		(37,747)	-	25,824,366
Reinsurance & Other	171,436,859	110,421,754	9,901,559	291,760,172	1,649,858	30,344	1,104,904	-	294,545,278
Total Medical Expenses	1,504,110,667	1,118,598,926	214,543,972	2,837,253,564	228,933,768	25,682,035	25,522,871	426,559	3,117,818,796
Medical Loss Ratio	95.9%	87.3%	94.2%	92.2%	92.0%	99.9%	84.1%	68.8%	92.1%
GROSS MARGIN	**65,069,295**	**163,046,445**	**13,263,693**	**241,379,433**	**19,784,514**	**16,389**	**4,816,857**	**193,621**	**266,190,816**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				63,186,291	6,281,365	692,126	958,919	159,546	71,278,246
Professional fees				2,579,472	158,228	269,205	7,251	5,123	3,019,280
Purchased services				8,718,650	977,627	102,373	216,809	-	10,015,459
Printing & Postage				2,781,545	798,752	84,029	129,185	-	3,793,510
Depreciation & Amortization				3,352,097			7,143	-	3,359,240
Other expenses				14,323,736	8,971	1,076	67,040	16,062	14,416,884
Indirect cost allocation & Occupancy				(2,428,494)	5,203,943	537,689	90,686	13,740	3,417,563
Total Administrative Expenses				92,513,297	13,428,885	1,686,498	1,477,032	194,471	109,300,183
Admin Loss Ratio				3.0%	5.4%	6.6%	4.9%	31.4%	3.2%
INCOME (LOSS) FROM OPERATIONS				148,866,136	6,355,629	(1,670,108)	3,339,825	(849)	156,890,633
INVESTMENT INCOME									(17,770,138)
TOTAL MCO TAX				1,412,480					1,412,480
TOTAL GRANT INCOME				(30,303)					(30,303)
OTHER INCOME				8,808					8,808
CHANGE IN NET ASSETS				**$ 150,257,121**	**$ 6,355,629**	**$ (1,670,108)**	**$ 3,339,825**	**$ (849)**	**$ 140,511,480**
BUDGETED CHANGE IN NET ASSETS				(57,279,818)	(3,693,004)	(850,191)	1,213,038	(44,209)	(53,154,184)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 207,536,939	$ 10,048,633	$ (819,917)	$ 2,126,787	$ 43,360	$ 193,665,664

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Balance Sheet: As of March 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$864,534,685	Accounts Payable	$53,616,094
Short-term Investments	976,302,147	Medical Claims liability	968,091,399
Capitation receivable	162,936,428	Accrued Payroll Liabilities	12,886,988
Receivables - Other	45,316,226	Deferred Revenue	10,259,097
Prepaid expenses	12,201,976	Deferred Lease Obligations	101,118
		Capitation and Withholds	183,659,361
Total Current Assets	**2,061,291,462**	**Total Current Liabilities**	**1,228,614,056**
Capital Assets			
Furniture & Equipment	46,311,601		
Building/Leasehold Improvements	9,240,650		
505 City Parkway West	52,236,708		
	107,788,959		
Less: accumulated depreciation	(62,617,634)		
Capital assets, net	45,171,325		
		Other (than pensions) post employment benefits liability	32,016,300
Other Assets		Net Pension Liabilities	30,157,322
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	48,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,290,787,678**
Cash and Cash Equivalents	2,129,736		
Investments	571,759,360	**Deferred Inflows**	
Total Board-designated Assets	573,889,097	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
		Change in Assumptions	2,709,945
Total Other Assets	622,988,010	OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,729,450,797**	TNE	106,030,210
		Funds in Excess of TNE	1,343,262,063
Deferred Outflows		**TOTAL NET POSITION**	1,449,292,273
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	**2,744,443,094**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,744,443,094**

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Board Designated Reserve and TNE Analysis: As of March 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	233,207,327				
	Tier 1 - MetLife	231,884,690				
Board-designated Reserve		465,092,017	376,403,419	583,160,688	88,688,598	(118,068,671)
	Tier 2 - Payden & Rygel	54,473,637				
	Tier 2 - MetLife	54,323,443				
TNE Requirement		108,797,080	106,030,210	106,030,210	2,766,870	2,766,870
	Consolidated:	**573,889,097**	**482,433,629**	**689,190,898**	**91,455,468**	**(115,301,802)**
	Current reserve level	*1.67*	*1.40*	*2.00*		

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Net Assets Analysis: As of March 2022

Category	Item Description	Amount (millions)	%
	Total Net Position @ 03/31/2022:	**$ 1,449.3**	**100.0%**
Resources Assigned	Board Designated Reserve	**$ 573.9**	**39.6%**
	Capital Assets, net of depreciation	**$ 45.2**	**3.1%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	18.8	1.3%
	Intergovernmental Transfers (IGT)	27.1	1.9%
	Mind OC Grant	1.0	0.1%
	CalFresh Outreach Strategy	2.0	0.1%
	Digital Transformation and Workplace Modernization	100.0	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	3.4%
	Subtotal:	**$ 198.9**	**13.7%**
Resources Available for New Initiatives	Homeless Health Initiative	48.8	
	Intergovernmental Transfers (IGT)	26.7	
	Unallocated/Unassigned	555.8	
	Subtotal:	**$ 631.3**	**43.6%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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Homeless Health Initiative and Allocated Funds: As of March 2022

		Amount
Program Commitment	**$**	**100,000,000**
Funds Allocation, approved initiatives:		
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Day Habilitation (County for HomeKey)	2,500,000	
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	
CalOptima Homeless Response Team	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087	
FQHC (Community Health Center) Expansion and HHI Support	570,000	
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000	
Vaccination Intervention and Member Incentive Strategy	400,000	
Street Medicine	8,000,000	
Funds Allocation Total	**$**	**51,201,087**
Program Commitment Balance, available for new initiatives*	**$**	**48,798,913**

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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Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person

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UNAUDITED FINANCIAL STATEMENTS

March 2022

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CalOptima - Consolidated
Financial Highlights
For the Nine Months Ended March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
886,480	839,216	47,264	5.6%	Member Months	7,803,093	7,576,567	226,526	3.0%
474,145,493	278,619,869	195,525,624	70.2%	Revenues	3,384,009,612	2,825,166,821	558,842,791	19.8%
438,035,044	273,909,120	(164,125,924)	(59.9%)	Medical Expenses	3,117,818,796	2,752,731,329	(365,087,467)	(13.3%)
12,147,211	15,607,216	3,460,005	22.2%	Administrative Expenses	109,300,183	133,089,676	23,789,493	17.9%
23,963,238	**(10,896,467)**	**34,859,705**	**319.9%**	**Operating Margin**	**156,890,633**	**(60,654,184)**	**217,544,817**	**358.7%**
(7,155,705)	833,334	(7,989,039)	(958.7%)	Non Operating Income (Loss)	(16,379,153)	7,500,000	(23,879,153)	(318.4%)
16,807,533	**(10,063,133)**	**26,870,666**	**267.0%**	**Change in Net Assets**	**140,511,480**	**(53,154,184)**	**193,665,664**	**364.3%**
92.4%	98.3%	5.9%		Medical Loss Ratio	92.1%	97.4%	5.3%	
2.6%	5.6%	3.0%		Administrative Loss Ratio	3.2%	4.7%	1.5%	
5.1%	(3.9%)	9.0%		Operating Margin Ratio	4.6%	(2.1%)	6.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.2%	98.3%	9.1%		*MLR (excluding Directed Payments)	91.4%	97.4%	6.0%	
3.6%	5.6%	2.0%		*ALR (excluding Directed Payments)	3.5%	4.7%	1.2%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima
Financial Dashboard
For the Nine Months Ended March 31, 2022

March

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	869,019	821,827	47,192	5.7%
OneCare Connect	14,587	15,175	(588)	(3.9%)
OneCare	2,461	1,792	669	37.3%
PACE	413	422	(9)	(2.1%)
MSSP	459	625	(166)	(26.6%)
Total*	886,480	839,216	47,264	5.6%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 28,479	$ (10,093)	$ 38,572	382.2%
OneCare Connect	(3,016)	(730)	(2,286)	(313.2%)
OneCare	(892)	(84)	(808)	(961.9%)
PACE	439	29	410	1413.8%
MSSP	(1)	(19)	18	94.7%
505 Bldg.	-	-	-	0.0%
Investment Income	(8,202)	833	(9,035)	(1084.6%)
Total	$ 16,807	$ (10,064)	$ 26,871	267.0%

MLR	Actual	Budget	% Point Var
Medi-Cal	91.5%	98.7%	7.3
OneCare Connect	105.6%	96.0%	(9.6)
OneCare	123.3%	95.6%	(27.7)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,141	$ 13,164	$ 3,023	23.0%
OneCare Connect	1,517	1,902	384	20.2%
OneCare	207	181	(26)	(14.3%)
PACE	213	267	55	20.4%
MSSP	69	93	24	25.9%
Total	$ 12,147	$ 15,607	$ 3,460	22.2%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,075	1,205	130
OneCare Connect	175	210	35
OneCare	10	9	(1)
PACE	89	117	27
MSSP	15	18	3
Total	1,364	1,558	194

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	808	682	(126)
OneCare Connect	83	72	(11)
OneCare	249	193	(56)
PACE	5	4	(1)
MSSP	30	35	5
Consolidated	650	539	(111)

July to March

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	7,646,253	7,420,933	225,320	3.0%
OneCare Connect	132,819	135,991	(3,172)	(2.3%)
OneCare	20,292	15,992	4,300	26.9%
PACE	3,729	3,651	78	2.1%
MSSP	1,368	1,535	(167)	(10.9%)
Total*	7,803,093	7,576,567	226,526	3.0%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 150,257	$ (57,280)	$ 207,537	362.3%
OneCare Connect	6,356	(3,693)	10,049	272.1%
OneCare	(1,670)	(850)	(820)	(96.5%)
PACE	3,340	1,213	2,127	175.4%
MSSP	(1)	(44)	43	97.7%
505 Bldg.	-	-	-	0.0%
Investment Income	(17,770)	7,500	(25,270)	(336.9%)
Total	$ 140,512	$ (53,154)	$ 193,666	364.3%

MLR	Actual	Budget	% Point Var
Medi-Cal	92.2%	97.8%	5.7
OneCare Connect	92.0%	94.8%	2.7
OneCare	99.9%	95.9%	(4.0)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 92,513	$ 112,272	$ 19,759	17.6%
OneCare Connect	13,429	16,882	3,453	20.5%
OneCare	1,686	1,616	(71)	(4.4%)
PACE	1,477	2,084	607	29.1%
MSSP	194	236	42	17.8%
Total	$ 109,300	$ 133,090	$ 23,790	17.9%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	9,715	10,920	1,205
OneCare Connect	1,666	1,886	220
OneCare	89	84	(6)
PACE	825	1,028	203
MSSP	50	54	4
Total	12,345	13,971	1,627

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	787	680	(108)
OneCare Connect	80	72	(8)
OneCare	227	191	(36)
PACE	5	4	(1)
MSSP	27	28	1
Consolidated	632	542	(90)

Note:* Total membership does not include MSSP

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended March 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	886,480		839,216		47,264	
REVENUE						
Medi-Cal	$ 440,839,516	$ 507.28	$ 243,626,017	$ 296.44	$ 197,213,499	$ 210.84
OneCare Connect	26,703,543	1,830.64	29,073,861	1,915.91	(2,370,318)	(85.27)
OneCare	2,939,367	1,194.38	2,199,837	1,227.59	739,530	(33.21)
PACE	3,454,052	8,363.32	3,441,422	8,155.03	12,630	208.29
MSSP	209,015	455.37	278,732	445.97	(69,717)	9.40
Total Operating Revenue	474,145,493	534.86	278,619,869	332.00	195,525,624	202.86
MEDICAL EXPENSES						
Medi-Cal	403,265,406	464.05	240,554,672	292.71	(162,710,734)	(171.34)
OneCare Connect	28,202,216	1,933.38	27,902,269	1,838.70	(299,947)	(94.68)
OneCare	3,624,398	1,472.73	2,102,789	1,173.43	(1,521,609)	(299.30)
PACE	2,802,245	6,785.10	3,145,076	7,452.79	342,831	667.69
MSSP	140,778	306.71	204,314	326.90	63,536	20.19
Total Medical Expenses	438,035,044	494.13	273,909,120	326.39	(164,125,924)	(167.74)
GROSS MARGIN	36,110,449	40.73	4,710,749	5.61	31,399,700	35.12
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,616,155	8.59	9,859,527	11.75	2,243,372	3.16
Professional fees	269,227	0.30	806,646	0.96	537,419	0.66
Purchased services	1,392,267	1.57	1,215,789	1.45	(176,478)	(0.12)
Printing & Postage	206,504	0.23	639,498	0.76	432,994	0.53
Depreciation & Amortization	342,995	0.39	492,900	0.59	149,905	0.20
Other expenses	1,980,830	2.23	2,122,672	2.53	141,842	0.30
Indirect cost allocation & Occupancy expense	339,233	0.38	470,184	0.56	130,951	0.18
Total Administrative Expenses	12,147,211	13.70	15,607,216	18.60	3,460,005	4.90
INCOME (LOSS) FROM OPERATIONS	23,963,238	27.03	(10,896,467)	(12.98)	34,859,705	40.01
INVESTMENT INCOME						
Interest income	879,120	0.99	833,334	0.99	45,786	-
Realized gain/(loss) on investments	(183,301)	(0.21)	-	-	(183,301)	(0.21)
Unrealized gain/(loss) on investments	(8,897,726)	(10.04)	-	-	(8,897,726)	(10.04)
Total Investment Income	(8,201,907)	(9.25)	833,334	0.99	(9,035,241)	(10.24)
TOTAL MCO TAX	1,076,505	1.21	-	-	1,076,505	1.21
TOTAL GRANT INCOME	(30,303)	(0.03)	-	-	(30,303)	(0.03)
CHANGE IN NET ASSETS	**16,807,533**	**18.96**	**(10,063,133)**	**(11.99)**	**26,870,666**	**30.95**
MEDICAL LOSS RATIO	**92.4%**		**98.3%**		**5.9%**	
ADMINISTRATIVE LOSS RATIO	**2.6%**		**5.6%**		**3.0%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Nine Months Ended March 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	7,803,093		7,576,567		226,526	
REVENUE						
Medi-Cal	$ 3,078,632,998	$ 402.63	$ 2,523,140,518	$ 340.00	$ 555,492,480	$ 62.63
OneCare Connect	248,718,282	1,872.61	252,888,311	1,859.60	(4,170,029)	13.01
OneCare	25,698,424	1,266.43	18,798,103	1,175.47	6,900,321	90.96
PACE	30,339,728	8,136.16	29,654,978	8,122.43	684,750	13.73
MSSP	620,181	453.35	684,911	446.20	(64,730)	7.15
Total Operating Revenue	3,384,009,612	433.68	2,825,166,821	372.88	558,842,791	60.80
MEDICAL EXPENSES						
Medi-Cal	2,837,253,564	371.06	2,468,147,888	332.59	(369,105,676)	(38.47)
OneCare Connect	228,933,768	1,723.65	239,699,202	1,762.61	10,765,434	38.96
OneCare	25,682,035	1,265.62	18,032,491	1,127.59	(7,649,544)	(138.03)
PACE	25,522,871	6,844.43	26,358,335	7,219.48	835,464	375.05
MSSP	426,559	311.81	493,413	321.44	66,854	9.63
Total Medical Expenses	3,117,818,796	399.56	2,752,731,329	363.32	(365,087,467)	(36.24)
GROSS MARGIN	266,190,816	34.12	72,435,492	9.56	193,755,324	24.56
ADMINISTRATIVE EXPENSES						
Salaries and benefits	71,278,246	9.13	84,435,673	11.14	13,157,427	2.01
Professional fees	3,019,280	0.39	6,431,326	0.85	3,412,046	0.46
Purchased services	10,015,459	1.28	11,430,636	1.51	1,415,177	0.23
Printing & Postage	3,793,510	0.49	5,095,482	0.67	1,301,972	0.18
Depreciation & Amortization	3,359,240	0.43	4,436,100	0.59	1,076,860	0.16
Other expenses	14,416,884	1.85	17,278,803	2.28	2,861,919	0.43
Indirect cost allocation & Occupancy expense	3,417,563	0.44	3,981,656	0.53	564,093	0.09
Total Administrative Expenses	109,300,183	14.01	133,089,676	17.57	23,789,493	3.56
INCOME (LOSS) FROM OPERATIONS	156,890,633	20.11	(60,654,184)	(8.01)	217,544,817	28.12
INVESTMENT INCOME						
Interest income	5,827,950	0.75	7,500,000	0.99	(1,672,050)	(0.24)
Realized gain/(loss) on investments	(1,071,484)	(0.14)	-	-	(1,071,484)	(0.14)
Unrealized gain/(loss) on investments	(22,526,604)	(2.89)	-	-	(22,526,604)	(2.89)
Total Investment Income	(17,770,138)	(2.28)	7,500,000	0.99	(25,270,138)	(3.27)
TOTAL MCO TAX	1,412,480	0.18	-	-	1,412,480	0.18
TOTAL GRANT INCOME	(30,303)	-	-	-	(30,303)	-
OTHER INCOME	8,808	-	-	-	8,808	-
CHANGE IN NET ASSETS	**140,511,480**	**18.01**	**(53,154,184)**	**(7.02)**	**193,665,664**	**25.03**
MEDICAL LOSS RATIO	**92.1%**		**97.4%**		**5.3%**	
ADMINISTRATIVE LOSS RATIO	**3.2%**		**4.7%**		**1.5%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended March 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	543,528	313,081	12,410	869,019	14,587	2,461	413	459	886,480
REVENUES									
Capitation Revenue	218,386,664	$ 182,797,912	$ 39,654,941	$ 440,839,516	$ 26,703,543	$ 2,939,367	$ 3,454,052	$ 209,015	$ 474,145,493
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	218,386,664	182,797,912	39,654,941	440,839,516	26,703,543	2,939,367	3,454,052	209,015	474,145,493
MEDICAL EXPENSES									
Provider Capitation	47,582,030	50,596,736	7,892,558	106,071,325	10,520,456	837,702			117,429,483
Facilities	25,799,604	26,163,358	8,525,272	60,488,234	5,078,647	1,154,656	768,551		67,490,088
Professional Claims	23,923,939	13,915,614	1,407,295	39,246,849	1,307,055	122,887	740,703		41,417,494
Prescription Drugs	141,482	(808,598)	744	(666,372)	8,294,393	1,335,502	357,959		9,321,482
MLTSS	43,076,433	4,597,564	1,689,836	49,363,832	1,484,304	135,869	10,302	37,165	51,031,472
Medical Management	2,569,678	1,620,724	343,411	4,533,813	1,103,020	32,258	874,047	103,613	6,646,751
Quality Incentives	1,183,918	803,567	30,335	2,017,820	214,065		(79,197)		2,152,688
Reinsurance & Other	77,951,626	54,449,187	9,809,093	142,209,905	200,275	5,525	129,880		142,545,585
Total Medical Expenses	222,228,710	151,338,152	29,698,544	403,265,406	28,202,216	3,624,398	2,802,245	140,778	438,035,044
Medical Loss Ratio	101.8%	82.8%	74.9%	91.5%	105.6%	123.3%	81.1%	67.4%	92.4%
GROSS MARGIN	**(3,842,046)**	**31,459,760**	**9,956,396**	**37,574,110**	**(1,498,673)**	**(685,032)**	**651,807**	**68,237**	**36,110,449**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				6,788,705	595,174	82,161	92,840	57,275	7,616,155
Professional fees				254,155	(16,241)	29,107		2,207	269,227
Purchased services				1,200,823	114,340	13,117	63,988		1,392,267
Printing & Postage				126,216	39,119	13,394	27,776		206,504
Depreciation & Amortization				342,626			370		342,995
Other expenses				1,961,665	1,225		14,049	3,891	1,980,830
Indirect cost allocation & Occupancy				(533,170)	783,681	69,669	13,550	5,502	339,233
Total Administrative Expenses				10,141,019	1,517,297	207,447	212,572	68,875	12,147,211
Admin Loss Ratio				2.3%	5.7%	7.1%	6.2%	33.0%	2.6%
INCOME (LOSS) FROM OPERATIONS				27,433,091	(3,015,971)	(892,479)	439,235	(638)	23,963,238
INVESTMENT INCOME									(8,201,907)
TOTAL MCO TAX				1,076,505					1,076,505
TOTAL GRANT INCOME				(30,303)					(30,303)
CHANGE IN NET ASSETS				**$ 28,479,293**	**$ (3,015,971)**	**$ (892,479)**	**$ 439,235**	**$ (638)**	**$ 16,807,533**
BUDGETED CHANGE IN NET ASSETS				(10,092,623)	(730,167)	(84,408)	29,243	(18,512)	(10,063,133)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 38,571,916	$ (2,285,804)	$ (808,071)	$ 409,992	$ 17,874	$ 26,870,666

Note:* Total membership does not include MSSP

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Nine Months Ended March 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	4,824,284	2,715,463	106,506	7,646,253	132,819	20,292	3,729	1,368	7,803,093
REVENUES									
Capitation Revenue	1,569,179,962	$ 1,281,645,370	$ 227,807,665	3,078,632,998	$ 248,718,282	$ 25,698,424	$ 30,339,728	620,181	$ 3,384,009,612
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,569,179,962	1,281,645,370	227,807,665	3,078,632,998	248,718,282	25,698,424	30,339,728	620,181	3,384,009,612
MEDICAL EXPENSES									
Provider Capitation	412,278,933	445,618,677	81,138,304	939,035,915	98,883,147	7,083,374		-	1,045,002,435
Facilities	227,070,072	227,249,057	50,765,148	505,084,278	37,101,228	8,145,803	6,553,179	-	556,884,488
Professional Claims	195,736,381	101,667,874	12,766,566	310,170,820	10,050,586	938,327	7,119,620	-	328,279,354
Prescription Drugs	128,614,146	175,306,528	40,503,899	344,424,574	56,950,664	8,632,130	2,923,153	-	412,930,520
MLTSS	331,526,775	36,201,630	15,950,336	383,678,741	12,992,965	524,312	369,269	91,938	397,657,225
Medical Management	22,657,759	13,657,361	2,924,647	39,239,767	9,302,505	327,746	7,490,492	334,621	56,695,131
Quality Incentives	14,789,741	8,476,044	593,513	23,859,298	2,002,815		(37,747)	-	25,824,366
Reinsurance & Other	171,436,859	110,421,754	9,901,559	291,760,172	1,649,858	30,344	1,104,904	-	294,545,278
Total Medical Expenses	1,504,110,667	1,118,598,926	214,543,972	2,837,253,564	228,933,768	25,682,035	25,522,871	426,559	3,117,818,796
Medical Loss Ratio	95.9%	87.3%	94.2%	92.2%	92.0%	99.9%	84.1%	68.8%	92.1%
GROSS MARGIN	**65,069,295**	**163,046,445**	**13,263,693**	**241,379,433**	**19,784,514**	**16,389**	**4,816,857**	**193,621**	**266,190,816**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	63,186,291	6,281,365	692,126	958,919	159,546	71,278,246			
Professional fees	2,579,472	158,228	269,205	7,251	5,123	3,019,280			
Purchased services	8,718,650	977,627	102,373	216,809	-	10,015,459			
Printing & Postage	2,781,545	798,752	84,029	129,185	-	3,793,510			
Depreciation & Amortization	3,352,097			7,143	-	3,359,240			
Other expenses	14,323,736	8,971	1,076	67,040	16,062	14,416,884			
Indirect cost allocation & Occupancy	(2,428,494)	5,203,943	537,689	90,686	13,740	3,417,563			
Total Administrative Expenses	92,513,297	13,428,885	1,686,498	1,477,032	194,471	109,300,183			
Admin Loss Ratio	3.0%	5.4%	6.6%	4.9%	31.4%	3.2%			
INCOME (LOSS) FROM OPERATIONS	148,866,136	6,355,629	(1,670,108)	3,339,825	(849)	156,890,633			
INVESTMENT INCOME						(17,770,138)			
TOTAL MCO TAX	1,412,480					1,412,480			
TOTAL GRANT INCOME	(30,303)					(30,303)			
OTHER INCOME	8,808					8,808			
CHANGE IN NET ASSETS	**$ 150,257,121**	**$ 6,355,629**	**$ (1,670,108)**	**$ 3,339,825**	**$ (849)**	**$ 140,511,480**			
BUDGETED CHANGE IN NET ASSETS	(57,279,818)	(3,693,004)	(850,191)	1,213,038	(44,209)	(53,154,184)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 207,536,939	$ 10,048,633	$ (819,917)	$ 2,126,787	$ 43,360	$ 193,665,664			

Note:* Total membership does not include MSSP

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March 31, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $16.8 million, $26.9 million favorable to budget
- Operating surplus is $24.0 million, with a deficit in non-operating income of $7.2 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $140.5 million, $193.7 million favorable to budget
- Operating surplus is $156.9 million, with a deficit in non-operating income of $16.4 million

Change in Net Assets by Line of Business (LOB) ($ millions):

March				July-March		
Actual	Budget	Variance		Actual	Budget	Variance
27.4	(10.1)	37.5	Medi-Cal	148.9	(57.3)	206.1
(3.0)	(0.7)	(2.3)	OCC	6.4	(3.7)	10.0
(0.9)	(0.1)	(0.8)	OneCare	(1.7)	(0.9)	(0.8)
0.4	0.0	0.4	PACE	3.3	1.2	2.1
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.0)	0.0
24.0	**(10.9)**	**34.9**	**Operating**	**156.9**	**(60.7)**	**217.5**
(7.2)	0.8	(8.0)	Inv./Rental Inc, MCO tax	(16.4)	7.5	(23.9)
(7.2)	**0.8**	**(8.0)**	**Non-Operating**	**(16.4)**	**7.5**	**(23.9)**
16.8	**(10.1)**	**26.9**	**TOTAL**	**140.5**	**(53.2)**	**193.7**

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CalOptima - Consolidated
Enrollment Summary
For the Nine Months Ended March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
120,055	117,722	2,333	2.0%	SPD	1,071,006	1,055,764	15,242	1.4%
302,224	294,326	7,898	2.7%	TANF Child	2,705,268	2,667,218	38,050	1.4%
118,077	106,314	11,763	11.1%	TANF Adult	1,019,810	960,805	59,005	6.1%
3,172	3,191	(19)	(0.6%)	LTC	28,200	28,719	(519)	(1.8%)
313,081	289,115	23,966	8.3%	MCE	2,715,463	2,607,996	107,467	4.1%
12,410	11,159	1,251	11.2%	WCM	106,506	100,431	6,075	6.0%
869,019	**821,827**	**47,192**	**5.7%**	**Medi-Cal Total**	**7,646,253**	**7,420,933**	**225,320**	**3.0%**
14,587	**15,175**	**(588)**	**(3.9%)**	**OneCare Connect**	**132,819**	**135,991**	**(3,172)**	**(2.3%)**
2,461	**1,792**	**669**	**37.3%**	**OneCare**	**20,292**	**15,992**	**4,300**	**26.9%**
413	**422**	**(9)**	**(2.1%)**	**PACE**	**3,729**	**3,651**	**78**	**2.1%**
459	**625**	**(166)**	**(26.6%)**	**MSSP**	**1,368**	**1,535**	**(167)**	**(10.9%)**
886,480	**839,216**	**47,264**	**5.6%**	**CalOptima Total**	**7,803,093**	**7,576,567**	**226,526**	**3.0%**
				Enrollment (by Network)				
203,094	190,916	12,178	6.4%	HMO	1,780,083	1,720,283	59,800	3.5%
232,840	225,917	6,923	3.1%	PHC	2,069,386	2,046,370	23,016	1.1%
212,780	201,270	11,510	5.7%	Shared Risk Group	1,869,916	1,823,124	46,792	2.6%
220,305	203,724	16,581	8.1%	Fee for Service	1,926,868	1,831,156	95,712	5.2%
869,019	**821,827**	**47,192**	**5.7%**	**Medi-Cal Total**	**7,646,253**	**7,420,933**	**225,320**	**3.0%**
14,587	**15,175**	**(588)**	**(3.9%)**	**OneCare Connect**	**132,819**	**135,991**	**(3,172)**	**(2.3%)**
2,461	**1,792**	**669**	**37.3%**	**OneCare**	**20,292**	**15,992**	**4,300**	**26.9%**
413	**422**	**(9)**	**(2.1%)**	**PACE**	**3,729**	**3,651**	**78**	**2.1%**
459	**625**	**(166)**	**(26.6%)**	**MSSP**	**1,368**	**1,535**	**(167)**	**(10.9%)**
886,480	**839,216**	**47,264**	**5.6%**	**CalOptima Total**	**7,803,093**	**7,576,567**	**226,526**	**3.0%**

*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	10,887	10,843				97,306	97,264	42
TANF Child	57,684	57,453	57,592	57,944	58,108	58,236	58,526	58,795	58,905				523,243	512,406	10,837
TANF Adult	33,827	34,099	34,339	34,622	35,046	35,411	35,758	36,052	36,426				315,580	298,183	17,397
LTC		1	3	1		1	1		2				9		9
MCE	88,797	89,334	90,159	91,017	91,516	92,159	93,225	93,841	94,771				824,819	794,340	30,479
WCM	2,114	2,193	2,177	2,133	2,130	2,143	2,103	1,986	2,147				19,126	18,090	1,036
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**	**198,787**	**200,454**	**201,561**	**203,094**				**1,780,083**	**1,720,283**	**59,800**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953	6,926	6,861	6,880	6,894				62,086	64,074	(1,988)
TANF Child	155,214	154,985	155,440	155,771	156,156	156,251	156,692	157,039	156,984				1,404,532	1,390,030	14,502
TANF Adult	14,006	14,054	14,197	14,390	14,667	14,851	14,985	15,115	15,270				131,535	124,133	7,402
LTC		2	1			1							4		4
MCE	44,256	44,359	44,580	44,754	44,973	45,241	45,668	45,753	46,013				405,597	406,285	(688)
WCM	7,304	7,368	7,236	7,322	7,178	7,262	7,246	7,037	7,679				65,632	61,848	3,784
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**	**230,532**	**231,452**	**231,824**	**232,840**				**2,069,386**	**2,046,370**	**23,016**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122	10,095	10,096	10,086	10,077				90,720	92,966	(2,246)
TANF Child	59,085	58,837	58,641	58,541	58,523	58,347	58,363	58,200	58,279				526,816	535,198	(8,382)
TANF Adult	33,013	33,123	33,374	33,745	34,109	34,482	34,824	35,120	35,551				307,341	297,980	9,361
LTC	1	1	1		1			1					5		5
MCE	99,994	100,643	101,666	102,780	103,620	104,418	105,563	106,367	107,480				932,531	884,236	48,295
WCM	1,373	1,368	1,394	1,400	1,395	1,394	1,423	1,363	1,393				12,503	12,744	(241)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**	**208,736**	**210,269**	**211,137**	**212,780**				**1,869,916**	**1,823,124**	**46,792**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738	80,494	81,326	81,148	81,219				725,448	708,012	17,436
TANF Child	1	1	1	1	1	1	1	1	1				9		9
TANF Adult	1,318	1,351	1,392	1,408	1,435	1,465	1,529	1,568	1,563				13,029	10,440	2,589
LTC	2,788	2,778	2,806	2,847	2,864	2,870	2,914	2,624	2,846				25,337	25,983	(646)
MCE	3,612	3,813	4,013	4,268	4,489	4,889	4,982	5,145	5,468				40,679	23,419	17,260
WCM	16	16	18	20	15	18	16	16	19				154	135	19
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**	**89,737**	**90,768**	**90,502**	**91,116**				**804,656**	**767,989**	**36,667**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832	10,708	10,937	10,763	11,022				95,446	93,448	1,998
TANF Child	26,720	26,952	27,715	28,188	27,730	27,774	28,746	28,788	28,055				250,668	229,584	21,084
TANF Adult	26,224	26,653	27,382	27,916	28,150	28,339	29,265	29,129	29,267				252,325	230,069	22,256
LTC	309	314	305	316	321	332	292	332	324				2,845	2,736	109
MCE	53,947	54,384	55,449	56,467	56,714	56,885	58,967	59,675	59,349				511,837	499,716	12,121
WCM	993	962	999	1,030	1,009	975	1,053	898	1,172				9,091	7,614	1,477
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**	**125,013**	**129,260**	**129,585**	**129,189**				**1,122,212**	**1,063,167**	**59,045**
SPD	117,710	117,859	118,567	118,464	119,466	119,060	120,061	119,764	120,055				1,071,006	1,055,764	15,242
TANF Child	298,704	298,228	299,389	300,445	300,518	300,609	302,328	302,823	302,224				2,705,268	2,667,218	38,050
TANF Adult	108,388	109,280	110,684	112,081	113,407	114,548	116,361	116,984	118,077				1,019,810	960,805	59,005
LTC	3,098	3,096	3,116	3,164	3,186	3,204	3,207	2,957	3,172				28,200	28,719	(519)
MCE	290,606	292,533	295,867	299,286	301,312	303,592	308,405	310,781	313,081				2,715,463	2,607,996	107,467
WCM	11,800	11,907	11,824	11,905	11,727	11,792	11,841	11,300	12,410				106,506	100,431	6,075
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**	**852,805**	**862,203**	**864,609**	**869,019**				**7,646,253**	**7,420,933**	**225,320**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**	**14,933**	**14,686**	**14,579**	**14,587**				**132,819**	**135,991**	**(3,172)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**	**2,330**	**2,319**	**2,395**	**2,461**				**20,292**	**15,992**	**4,300**
PACE	**401**	**407**	**409**	**418**	**415**	**421**	**427**	**418**	**413**				**3,729**	**3,651**	**78**
MSSP							**452**	**457**	**459**				**1,368**	**1,535**	**(167)**
Grand Total	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**	**870,489**	**879,635**	**882,001**	**886,480**				**7,803,093**	**7,576,567**	**226,526**

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ENROLLMENT:

Overall, March enrollment was 886.480

- Favorable to budget 47,264 or 5.6% due to lower than expected enrollment during the COVID-19
- Increased 4,479 or 0.5% from Prior Month (PM) (February 2022)
- Increased 60,112 or 7.3% from Prior Year (PY) (March 2021)

Medi-Cal enrollment was 869,019

- Favorable to budget 47,192 or 5.7%
  - Medi-Cal Expansion (MCE) favorable 23,966
  - Temporary Assistance for Needy Families (TANF) favorable 19,661
  - Seniors and Persons with Disabilities (SPD) favorable 2,333
  - Whole Child Model (WCM) favorable 1,251
  - Long-Term Care (LTC) unfavorable 19
- Increased 4,410 from PM

OneCare Connect enrollment was 14,587

- Unfavorable to budget 588 or 3.9%
- Increased 8 from PM

OneCare enrollment was 2,461

- Favorable to budget 669 or 37.3%
- Increased 66 from PM

PACE enrollment was 413

- Unfavorable to budget 9 or 2.1%
- Decreased 5 from PM

MSSP enrollment was 459

- Unfavorable to budget 166 or 26.6% due to MSSP currently being under-staffed. There is a staff to member ratio that must be met
- Increased 2 from PM

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CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
869,019	**821,827**	**47,192**	**5.7%**	**Member Months**	**7,646,253**	**7,420,933**	**225,320**	**3.0%**
				Revenues				
440,839,516	243,626,017	197,213,499	80.9%	Capitation Revenue	3,078,632,998	2,523,140,518	555,492,480	22.0%
-	-	-	0.0%	Other Income	-	-	-	0.0%
440,839,516	**243,626,017**	**197,213,499**	**80.9%**	**Total Operating Revenue**	**3,078,632,998**	**2,523,140,518**	**555,492,480**	**22.0%**
				Medical Expenses				
108,089,145	89,287,407	(18,801,738)	(21.1%)	Provider Capitation	962,895,213	823,577,306	(139,317,907)	(16.9%)
60,488,234	66,698,966	6,210,732	9.3%	Facilities Claims	505,084,278	576,233,934	71,149,656	12.3%
39,246,849	32,069,885	(7,176,964)	(22.4%)	Professional Claims	310,170,820	280,964,385	(29,206,435)	(10.4%)
(666,372)	-	666,372	0.0%	Prescription Drugs	344,424,574	345,521,586	1,097,012	0.3%
49,363,832	43,368,525	(5,995,307)	(13.8%)	MLTSS	383,678,741	379,409,677	(4,269,064)	(1.1%)
4,533,813	5,822,358	1,288,545	22.1%	Medical Management	39,239,767	48,345,732	9,105,965	18.8%
142,209,905	3,307,531	(138,902,374)	(4199.6%)	Reinsurance & Other	291,760,172	14,095,268	(277,664,904)	(1969.9%)
403,265,406	**240,554,672**	**(162,710,734)**	**(67.6%)**	**Total Medical Expenses**	**2,837,253,564**	**2,468,147,888**	**(369,105,676)**	**(15.0%)**
37,574,110	**3,071,345**	**34,502,765**	**1123.4%**	**Gross Margin**	**241,379,433**	**54,992,630**	**186,386,803**	**338.9%**
				Administrative Expenses				
6,788,705	8,626,855	1,838,150	21.3%	Salaries, Wages & Employee Benefits	63,186,291	74,290,871	11,104,580	14.9%
254,155	746,868	492,713	66.0%	Professional Fees	2,579,472	5,762,924	3,183,452	55.2%
1,200,823	1,045,945	(154,878)	(14.8%)	Purchased Services	8,718,650	9,957,755	1,239,105	12.4%
126,216	466,328	340,112	72.9%	Printing and Postage	2,781,545	3,536,952	755,407	21.4%
342,626	492,500	149,874	30.4%	Depreciation & Amortization	3,352,097	4,432,500	1,080,403	24.4%
1,961,665	2,056,093	94,428	4.6%	Other Operating Expenses	14,323,736	16,947,731	2,623,995	15.5%
(533,170)	(270,621)	262,549	97.0%	Indirect Cost Allocation, Occupancy Expense	(2,428,494)	(2,656,285)	(227,791)	(8.6%)
10,141,019	**13,163,968**	**3,022,949**	**23.0%**	**Total Administrative Expenses**	**92,513,297**	**112,272,448**	**19,759,151**	**17.6%**
				Operating Tax				
15,521,041	13,839,560	1,681,481	12.1%	Tax Revenue	131,413,307	124,968,502	6,444,805	5.2%
14,444,536	13,839,560	(604,976)	(4.4%)	Premium Tax Expense	130,000,827	124,968,502	(5,032,325)	(4.0%)
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
1,076,505	-	1,076,505	**0.0%**	**Total Net Operating Tax**	1,412,480	-	1,412,480	**0.0%**
(30,303)	-	(30,303)	**0.0%**	**Total Grant Income**	(30,303)	-	(30,303)	**0.0%**
-	**-**	**-**	**0.0%**	**Other income**	**8,808**	**-**	**8,808**	**0.0%**
28,479,293	**(10,092,623)**	**38,571,916**	**382.2%**	**Change in Net Assets**	**150,257,121**	**(57,279,818)**	**207,536,939**	**362.3%**
91.5%	***98.7%***	***7.3%***	***7.4%***	***Medical Loss Ratio***	***92.2%***	***97.8%***	***5.7%***	***5.8%***
2.3%	***5.4%***	***3.1%***	***57.4%***	***Admin Loss Ratio***	***3.0%***	***4.4%***	***1.4%***	***32.5%***

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MEDI-CAL INCOME STATEMENT– MARCH MONTH:

REVENUES of $440.8 million are favorable to budget $197.2 million driven by:

- Favorable volume related variance of $14.0 million
- Favorable price related variance of $183.2 million
  - $138.9 million of FY 2020 hospital Directed Payment (DP)
  - $35.3 million due to favorable revenue rates and Proposition 56 risk corridor estimates
  - $4.3 million of Intergovernmental Transfers (IGT) 10 revenue

MEDICAL EXPENSES of $403.3 million are unfavorable to budget $162.7 million driven by:

- Unfavorable volume related variance of $13.8 million
- Unfavorable price related variance of $148.9 million
  - Reinsurance & Other expense unfavorable variance of $138.7 million due to FY 2020 DP
  - Provider Capitation expense unfavorable variance of $13.7 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
  - Professional Claims expense unfavorable variance of $5.3 million due to Incurred But Not Reported (IBNR) claims
  - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $3.5 million due to Incurred But Not Reported (IBNR) claims
  - Offset by:
    - Facilities Claims expense favorable variance of $10.0 million due to low utilization

ADMINISTRATIVE EXPENSES of $10.1 million are favorable to budget $3.0 million driven by:

- Salaries & Benefit expense favorable to budget $1.8 million
- Other Non-Salary expense favorable to budget $1.2 million

CHANGE IN NET ASSETS is $28.5 million, favorable to budget $38.6 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Nine Months Ending March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,587	**15,175**	**(588)**	**(3.9%)**	**Member Months**	**132,819**	**135,991**	**(3,172)**	**(2.3%)**
				Revenues				
2,538,563	2,796,063	(257,500)	(9.2%)	Medi-Cal Capitation Revenue	24,409,041	25,252,120	(843,079)	(3.3%)
18,023,493	20,464,226	(2,440,733)	(11.9%)	Medicare Capitation Revenue Part C	170,709,659	175,912,079	(5,202,420)	(3.0%)
6,141,487	5,813,572	327,915	5.6%	Medicare Capitation Revenue Part D	53,599,582	51,724,112	1,875,470	3.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
26,703,543	**29,073,861**	**(2,370,318)**	**(8.2%)**	**Total Operating Revenue**	**248,718,282**	**252,888,311**	**(4,170,029)**	**(1.6%)**
				Medical Expenses				
10,734,521	12,520,716	1,786,195	14.3%	Provider Capitation	100,885,962	106,459,927	5,573,965	5.2%
5,078,647	4,565,441	(513,206)	(11.2%)	Facilities Claims	37,101,228	39,302,957	2,201,729	5.6%
1,307,055	1,090,273	(216,782)	(19.9%)	Ancillary	10,050,586	9,395,195	(655,391)	(7.0%)
1,484,304	1,428,604	(55,700)	(3.9%)	MLTSS	12,992,965	12,837,822	(155,143)	(1.2%)
8,294,393	6,878,400	(1,415,993)	(20.6%)	Prescription Drugs	56,950,664	59,039,255	2,088,591	3.5%
1,103,020	1,235,095	132,075	10.7%	Medical Management	9,302,505	11,069,187	1,766,682	16.0%
200,275	183,740	(16,535)	(9.0%)	Other Medical Expenses	1,649,858	1,594,859	(54,999)	(3.4%)
28,202,216	**27,902,269**	**(299,947)**	**(1.1%)**	**Total Medical Expenses**	**228,933,768**	**239,699,202**	**10,765,434**	**4.5%**
(1,498,673)	**1,171,592**	**(2,670,265)**	**(227.9%)**	**Gross Margin**	**19,784,514**	**13,189,109**	**6,595,405**	**50.0%**
				Administrative Expenses				
595,174	913,450	318,276	34.8%	Salaries, Wages & Employee Benefits	6,281,365	7,905,897	1,624,532	20.5%
(16,241)	29,320	45,561	155.4%	Professional Fees	158,228	401,030	242,802	60.5%
114,340	119,752	5,412	4.5%	Purchased Services	977,627	1,022,053	44,426	4.3%
39,119	138,109	98,990	71.7%	Printing and Postage	798,752	1,242,981	444,229	35.7%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
1,225	21,075	19,850	94.2%	Other Operating Expenses	8,971	189,675	180,704	95.3%
783,681	680,053	(103,628)	(15.2%)	Indirect Cost Allocation	5,203,943	6,120,477	916,534	15.0%
1,517,297	**1,901,759**	**384,462**	**20.2%**	**Total Administrative Expenses**	**13,428,885**	**16,882,113**	**3,453,228**	**20.5%**
(3,015,971)	**(730,167)**	**(2,285,804)**	**(313.1%)**	**Change in Net Assets**	**6,355,629**	**(3,693,004)**	**10,048,633**	**272.1%**
105.6%	***96.0%***	***(9.6%)***	***(10.0%)***	***Medical Loss Ratio***	***92.0%***	***94.8%***	***2.7%***	***2.9%***
5.7%	***6.5%***	***0.9%***	***13.1%***	***Admin Loss Ratio***	***5.4%***	***6.7%***	***1.3%***	***19.1%***

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ONECARE CONNECT INCOME STATEMENT– MARCH MONTH:

REVENUES of $26.7 million are unfavorable to budget $2.4 million driven by:

- Unfavorable volume related variance of $1.1 million
- Unfavorable price related variance of $1.2 million

MEDICAL EXPENSES of $28.2 million are unfavorable to budget $0.3 million driven by:

- Favorable volume related variance of $1.1 million
- Unfavorable price related variance of $1.4 million
  - Prescription Drugs expense unfavorable variance of $1.7 million
  - Facilities claims expenses unfavorable variance of $0.7 million
  - Ancillary expense unfavorable variance of $0.3 million
  - Offset by:
    - Provider Capitation expense favorable variance of $1.3 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.4 million

CHANGE IN NET ASSETS is ($3.0) million, unfavorable to budget $2.3 million

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CalOptima
OneCare
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,461	**1,792**	**669**	**37.3%**	**Member Months**	**20,292**	**15,992**	**4,300**	**26.9%**
				Revenues				
2,110,360	1,479,997	630,363	42.6%	Medicare Part C revenue	17,502,340	12,823,813	4,678,527	36.5%
829,006	719,840	109,166	15.2%	Medicare Part D revenue	8,196,084	5,974,290	2,221,794	37.2%
2,939,367	**2,199,837**	**739,530**	**33.6%**	**Total Operating Revenue**	**25,698,424**	**18,798,103**	**6,900,321**	**36.7%**
				Medical Expenses				
837,702	586,382	(251,320)	(42.9%)	Provider Capitation	7,083,374	5,015,106	(2,068,268)	(41.2%)
1,154,656	643,947	(510,709)	(79.3%)	Inpatient	8,145,803	5,510,618	(2,635,185)	(47.8%)
122,887	76,850	(46,037)	(59.9%)	Ancillary	938,327	654,090	(284,237)	(43.5%)
135,869	29,745	(106,124)	(356.8%)	Skilled Nursing Facilities	524,312	263,414	(260,898)	(99.0%)
1,335,502	711,578	(623,924)	(87.7%)	Prescription Drugs	8,632,130	6,117,913	(2,514,217)	(41.1%)
32,258	52,961	20,703	39.1%	Medical Management	327,746	459,517	131,771	28.7%
5,525	1,326	(4,199)	(316.7%)	Other Medical Expenses	30,344	11,833	(18,511)	(156.4%)
3,624,398	**2,102,789**	**(1,521,609)**	**(72.4%)**	**Total Medical Expenses**	**25,682,035**	**18,032,491**	**(7,649,544)**	**(42.4%)**
(685,032)	**97,048**	**(782,080)**	**(805.9%)**	**Gross Margin**	**16,389**	**765,612**	**(749,223)**	**(97.9%)**
				Administrative Expenses				
82,161	75,347	(6,814)	(9.0%)	Salaries, wages & employee benefits	692,126	660,822	(31,304)	(4.7%)
29,107	29,166	59	0.2%	Professional fees	269,205	262,494	(6,711)	(2.6%)
13,117	9,167	(3,950)	(43.1%)	Purchased services	102,373	82,503	(19,870)	(24.1%)
13,394	15,823	2,429	15.4%	Printing and postage	84,029	142,407	58,378	41.0%
-	1,029	1,029	100.0%	Other operating expenses	1,076	9,261	8,185	88.4%
69,669	50,924	(18,745)	(36.8%)	Indirect cost allocation, occupancy expense	537,689	458,316	(79,373)	(17.3%)
207,447	**181,456**	**(25,991)**	**(14.3%)**	**Total Administrative Expenses**	**1,686,498**	**1,615,803**	**(70,695)**	**(4.4%)**
(892,479)	**(84,408)**	**(808,071)**	**(957.3%)**	**Change in Net Assets**	**(1,670,108)**	**(850,191)**	**(819,917)**	**(96.4%)**
123.3%	***95.6%***	***(27.7%)***	***(29.0%)***	***Medical Loss Ratio***	***99.9%***	***95.9%***	***(4.0%)***	***(4.2%)***
7.1%	***8.2%***	***1.2%***	***14.4%***	***Admin Loss Ratio***	***6.6%***	***8.6%***	***2.0%***	***23.7%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
413	**422**	**(9)**	**(2.1%)**	**Member Months**	**3,729**	**3,651**	**78**	**2.1%**
				Revenues				
2,629,132	2,603,944	25,188	1.0%	Medi-Cal Capitation Revenue	23,114,868	22,637,673	477,195	2.1%
616,391	685,158	(68,767)	(10.0%)	Medicare Part C Revenue	5,470,116	5,691,430	(221,314)	(3.9%)
208,529	152,320	56,209	36.9%	Medicare Part D Revenue	1,754,744	1,325,875	428,869	32.3%
3,454,052	**3,441,422**	**12,630**	**0.4%**	**Total Operating Revenue**	**30,339,728**	**29,654,978**	**684,750**	**2.3%**
				Medical Expenses				
874,047	1,045,708	171,661	16.4%	Medical Management	7,490,492	9,047,104	1,556,612	17.2%
768,551	779,745	11,194	1.4%	Facilities Claims	6,553,179	6,583,972	30,793	0.5%
740,703	714,130	(26,573)	(3.7%)	Professional Claims	7,119,620	5,992,512	(1,127,108)	(18.8%)
129,880	192,737	62,857	32.6%	Patient Transportation	1,104,904	1,381,340	276,436	20.0%
357,959	352,518	(5,441)	(1.5%)	Prescription Drugs	2,923,153	2,916,056	(7,097)	(0.2%)
10,302	54,921	44,619	81.2%	MLTSS	369,269	392,181	22,912	5.8%
(79,197)	5,317	84,514	1589.5%	Other Expenses	(37,747)	45,170	82,917	183.6%
2,802,245	**3,145,076**	**342,831**	**10.9%**	**Total Medical Expenses**	**25,522,871**	**26,358,335**	**835,464**	**3.2%**
651,807	**296,346**	**355,461**	**119.9%**	**Gross Margin**	**4,816,857**	**3,296,643**	**1,520,214**	**46.1%**
				Administrative Expenses				
92,840	164,263	71,423	43.5%	Salaries, wages & employee benefits	958,919	1,382,330	423,411	30.6%
-	167	167	100.0%	Professional fees	7,251	1,503	(5,748)	(382.5%)
63,988	40,925	(23,063)	(56.4%)	Purchased services	216,809	368,325	151,516	41.1%
27,776	19,238	(8,538)	(44.4%)	Printing and postage	129,185	173,142	43,957	25.4%
370	400	30	7.6%	Depreciation & amortization	7,143	3,600	(3,543)	(98.4%)
14,049	37,166	23,117	62.2%	Other operating expenses	67,040	110,209	43,169	39.2%
13,550	4,944	(8,606)	(174.1%)	Indirect Cost Allocation, Occupancy Expense	90,686	44,496	(46,190)	(103.8%)
212,572	**267,103**	**54,531**	**20.4%**	**Total Administrative Expenses**	**1,477,032**	**2,083,605**	**606,573**	**29.1%**
				Operating Tax				
6,129	-	6,129	0.0%	Tax Revenue	55,338	-	55,338	0.0%
6,129	-	(6,129)	0.0%	Premium Tax Expense	55,338	-	(55,338)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
439,235	**29,243**	**409,992**	**1402.0%**	**Change in Net Assets**	**3,339,825**	**1,213,038**	**2,126,787**	**175.3%**
81.1%	***91.4%***	***10.3%***	***11.2%***	***Medical Loss Ratio***	***84.1%***	***88.9%***	***4.8%***	***5.4%***
6.2%	***7.8%***	***1.6%***	***20.7%***	***Admin Loss Ratio***	***4.9%***	***7.0%***	***2.2%***	***30.7%***

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CalOptima
Multipurpose Senior Select Program
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
459	**625**	**(166)**	**(26.6%)**	**Member Months**	**1,368**	**1,535**	**(167)**	**(10.9%)**
				Revenues				
209,015	278,732	(69,717)	(25.0%)	Capitation Revenue	620,181	684,911	(64,730)	(9.5%)
209,015	**278,732**	**(69,717)**	**(25.0%)**	**Total Operating Revenue**	**620,181**	**684,911**	**(64,730)**	**(9.5%)**
				Medical Expenses				
103,613	168,079	64,466	38.4%	Medical Management	334,621	404,374	69,753	17.2%
				Waived Services				
-	165	165	100.0%	Minor home repairs	457	405	(52)	(12.8%)
6,299	10,300	4,001	38.8%	Non-medical home equipment	20,046	25,310	5,264	20.8%
3,831	4,188	357	8.5%	Chores	12,045	10,292	(1,753)	(17.0%)
2,403	3,589	1,186	33.0%	Personal care	11,171	8,819	(2,352)	(26.7%)
624	549	(75)	(13.7%)	In-home respite	897	1,349	452	33.5%
428	884	456	51.6%	Transportation	1,079	2,172	1,093	50.3%
441	1,319	878	66.6%	Home delivered meals	1,553	3,241	1,688	52.1%
88	209	121	57.7%	Food	90	513	423	82.5%
9,851	13,886	4,035	29.1%	Communications	28,686	34,122	5,436	15.9%
20	1,146	1,126	98.3%	Non-Covered Services	92	2,816	2,724	96.7%
13,180	-	(13,180)	0.0%	Protective Services	15,821	-	(15,821)	0.0%
103,613	168,079	64,466	38.4%	Total Medical Management	334,621	404,374	69,753	17.2%
37,165	36,235	(930)	(2.6%)	Other Medical Expenses	91,938	89,039	(2,899)	(3.3%)
140,778	**204,314**	**63,536**	**31.1%**	**Total Program Expenses**	**426,559**	**493,413**	**66,854**	**13.5%**
68,237	**74,418**	**(6,181)**	**(8.3%)**	**Gross Margin**	**193,621**	**191,498**	**2,123**	**1.1%**
				Administrative Expenses				
57,275	79,612	22,337	28.1%	Salaries, wages & employee benefits	159,546	195,753	36,207	18.5%
2,207	1,125	(1,082)	(96.2%)	Professional fees	5,123	3,375	(1,748)	(51.8%)
3,891	7,309	3,418	46.8%	Other operating expenses	16,062	21,927	5,865	26.7%
5,502	4,884	(618)	(12.7%)	Indirect Cost Allocation	13,740	14,652	912	6.2%
68,875	**92,930**	**24,055**	**25.9%**	**Total Administrative Expenses**	**194,471**	**235,707**	**41,236**	**17.5%**
(638)	**(18,512)**	**17,874**	**96.6%**	**Change in Net Assets**	**(849)**	**(44,209)**	**43,360**	**98.1%**
67.4%	***73.3%***	***5.9%***	***8.1%***	***Medical Loss Ratio***	***68.8%***	***72.0%***	***3.3%***	***4.5%***
33.0%	***33.3%***	***0.4%***	***1.2%***	***Admin Loss Ratio***	***31.4%***	***34.4%***	***3.1%***	***8.9%***

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CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Nine Months Ending March 31, 2022

March					July to March			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
38,506	54,250	15,744	29.0%	Purchase services	338,916	488,250	149,334	30.6%
174,793	206,000	31,207	15.1%	Depreciation & amortization	1,557,887	1,854,000	296,113	16.0%
19,565	19,750	185	0.9%	Insurance expense	176,083	177,750	1,667	0.9%
96,533	162,833	66,300	40.7%	Repair and maintenance	1,000,508	1,215,497	214,989	17.7%
43,434	43,000	(434)	(1.0%)	Other Operating Expense	447,753	387,000	(60,753)	(15.7%)
(372,832)	(485,833)	(113,001)	(23.3%)	Indirect allocation, Occupancy	(3,521,148)	(4,122,497)	(601,349)	(14.6%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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OTHER INCOME STATEMENTS – MARCH MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.9) million, unfavorable to budget $0.8 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $0.4 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($638), favorable to budget $17,874

- Carved out of Medi-Cal effective January 1, 2022

NET INVESTMENT INCOME

- Unfavorable variance of $9.0 million is primarily due unrealized losses in treasuries and corporate bonds due to continued increases to interest rates and the Federal Reserve's responses to inflation

CalOptima
Balance Sheet
March 31, 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$864,534,685	Accounts Payable	$53,616,094
Short-term Investments	976,302,147	Medical Claims liability	968,091,399
Capitation receivable	162,936,428	Accrued Payroll Liabilities	12,886,988
Receivables - Other	45,316,226	Deferred Revenue	10,259,097
Prepaid expenses	12,201,976	Deferred Lease Obligations	101,118
		Capitation and Withholds	183,659,361
Total Current Assets	**2,061,291,462**	**Total Current Liabilities**	**1,228,614,056**
Capital Assets			
Furniture & Equipment	46,311,601		
Building/Leasehold Improvements	9,240,650		
505 City Parkway West	52,236,708		
	107,788,959		
Less: accumulated depreciation	(62,617,634)		
Capital assets, net	45,171,325	Other (than pensions) post employment benefits liability	32,016,300
Other Assets		Net Pension Liabilities	30,157,322
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	48,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,290,787,678**
Cash and Cash Equivalents	2,129,736		
Investments	571,759,360	**Deferred Inflows**	
Total Board-designated Assets	573,889,097	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	622,988,010	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,729,450,797**	TNE	106,030,210
		Funds in Excess of TNE	1,343,262,063
Deferred Outflows		**TOTAL NET POSITION**	1,449,292,273
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	**2,744,443,094**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,744,443,094**

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CalOptima
Board Designated Reserve and TNE Analysis
as of March 31, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	233,207,327				
	Tier 1 - MetLife	231,884,690				
Board-designated Reserve		465,092,017	376,403,419	583,160,688	88,688,598	(118,068,671)
	Tier 2 - Payden & Rygel	54,473,637				
	Tier 2 - MetLife	54,323,443				
TNE Requirement		108,797,080	106,030,210	106,030,210	2,766,870	2,766,870
	Consolidated:	**573,889,097**	**482,433,629**	**689,190,898**	**91,455,468**	**(115,301,802)**
	Current reserve level	*1.67*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
March 31, 2022

	March	July to March
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	16,807,533	140,511,480
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	517,789	4,917,128
Changes in assets and liabilities:		
Prepaid expenses and other	1,090,122	(223,365)
Catastrophic reserves		
Capitation receivable	1,289,792	266,643,365
Medical claims liability	137,583,536	23,772,451
Deferred revenue	92,016	(3,327,729)
Payable to health networks	11,672,216	38,879,572
Accounts payable	12,750,264	7,201,673
Accrued payroll	(1,552,628)	(3,386,315)
Other accrued liabilities	(5,905)	(26,211)
Net cash provided by/(used in) operating activities	180,244,734	474,962,049
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	(66,777,643)	89,107,660
Change in Property and Equipment	(1,067,290)	(4,360,577)
Change in Board designated reserves	6,969,403	14,991,056
Change in Homeless Health Reserve	8,000,000	8,000,000
Net cash provided by/(used in) investing activities	(52,875,531)	107,738,138
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	127,369,203	582,700,187
CASH AND CASH EQUIVALENTS, beginning of period	$737,165,482	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**864,534,685**	**864,534,685**

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BALANCE SHEET – MARCH MONTH:

ASSETS of $2.7 billion increased $177.3 million from February or 6.9%

- Operating Cash and Short-term Investments net increase of $194.1 million due primarily to the receipt of DP of $138.7 million from the state
  - Operating cash increased $127.4 million
  - Short-term Investments increased $66.8 million
- Homeless Health Reserve decreased $8.0 million due to approved initiative for Street Medicine
- Board Designated Assets decreased $7.0 million due to net loss in investment portfolio
- Capitation Receivables decreased $2.3 million due to the timing of cash receipts

LIABILITIES of $1.3 billion increased $160.5 million from February or 14.2%

- Claims Liabilities increased $137.6 million due to accrual of FY 2020 DP that was paid in April 2022
- Accounts Payable increased $12.8 million due to the timing of accruals for the quarterly premium tax payment
- Capitation and Withhold increased $11.7 million due to timing of capitation payments

NET ASSETS of $1.4 billion, increased $16.8 million from February or 1.2%

CalOptima - Consolidated
Net Assets Analysis
For the Nine Months Ended March 31, 2022

Category	Item Description	Amount (millions)	%
	Total Net Position @ 03/31/2022:	**$ 1,449.3**	**100.0%**
Resources Assigned	Board Designated Reserve	**$ 573.9**	**39.6%**
	Capital Assets, net of depreciation	**$ 45.2**	**3.1%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	18.8	1.3%
	Intergovernmental Transfers (IGT)	27.1	1.9%
	Mind OC Grant	1.0	0.1%
	CalFresh Outreach Strategy	2.0	0.1%
	Digital Transformation and Workplace Modernization	100.0	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	3.4%
	Subtotal:	**$ 198.9**	**13.7%**
Resources Available for New Initiatives	Homeless Health Initiative	48.8	
	Intergovernmental Transfers (IGT)	26.7	
	Unallocated/Unassigned	555.8	
	Subtotal:	**$ 631.3**	**43.6%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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Summary of Homeless Health Initiatives and Allocated Funds
As of March 31, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Street Medicine	8,000,000		
Funds Allocation Total		**$**	**51,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**48,798,913**

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 March 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
February	Medi-Cal	Purchased Services – Disaster Recovery Technology Services	Purchased Services – Offsite Backup Tape Storage and Services	$25,000	To repurpose funds from Purchased Services - Disaster Recovery Technology Services to Purchased Services - Offsite Backup Tape Storage and Services to provide additional funds.	2021-22
March	Medi-Cal	Cert/Cont. Education - Leadership Series Quarterly	Training & Seminar	$28,000	To reallocate finding from Cert/Cont. Education Leadership Series to Training & Seminar for the funding of company-wide training from Dale Carnegie	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
May 5, 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, CalOptima is required to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. The validation audit includes a webinar validation and source documentation review for various Medicare Parts C and D measures/

  CalOptima has completed submission of reports to CMS ahead of February 7, 2022, and February 28, 2022 deadlines. RAC worked with the business owners to complete the Organization Assessment Instrument, Measure Overviews and additional supporting documents.

  On March 29, 2022, CMS notified CalOptima that potential data issues with the OC SNP-MOC, CDR and MTMP files and OCC CDR and MTMP files have been identified. Responses to the potential issues have been submitted to CMS; all data were accurate as submitted.

  The webinar validation is scheduled to take place on April 7, 2022 and April 13, 2022. Following the webinar validation, Advent is expected to requested sample selections for each of the reporting measures. CalOptima is working to collect the documents requested for submission ahead of the submission deadline.

- 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

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the CAP was accepted by CMS on 9/13/21.) As there were no comments/rebuttals to the Draft Audit Report, CMS released the Final Audit Report, with no changes to the findings, on 11/5/21.

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. 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.

On March 1, 2022, CalOptima in collaboration with BluePeak, held a mock IVA webinar for the FA program area. Mock IVA webinars for ODAG, SNP-MOC and CCQIPE will be held in April and May, respectively.

On April 5, 2022, CalOptima received approval from CMS on the IVA Work Plan. CalOptima will work with impacted departments and health networks to ensure completion of the IVA by the July 5, 2022 deadline.

2. Medi-Cal

- 2021 DHCS Medical Audit:

  DHCS hosted its audit via webinar from January 24, 2022 through February 4, 2022. The Entrance Conference was held on January 24, 2022.

  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 be provided for CalOptima's review. CalOptima will have fifteen (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, thirty (30) calendar days from the Exit Conference (slated for May 2022).

- 2022 Department of Managed Care (DMHC) Routine Examination:

  On February 9, 2022, the DMHC engaged CalOptima for the 2022 DMHC Routine Examination. This examination is routine and occurs every three (3) years. The examination will review CalOptima's fiscal and administrative affairs and includes an examination of CalOptima's financial reports.

  On April 5, 2022, CalOptima completed its submission of pre-audit deliverables; this submission was provided ahead of schedule. The formal examination will begin on May 16, 2022 and will be conducted remotely. CalOptima delegates are not expected to participate.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of March 2022.

C. Updates on Internal and Health Network Monitoring and Audits

- No significant issues to report related to the monthly self-reported Key Performance Indicators (KPI).

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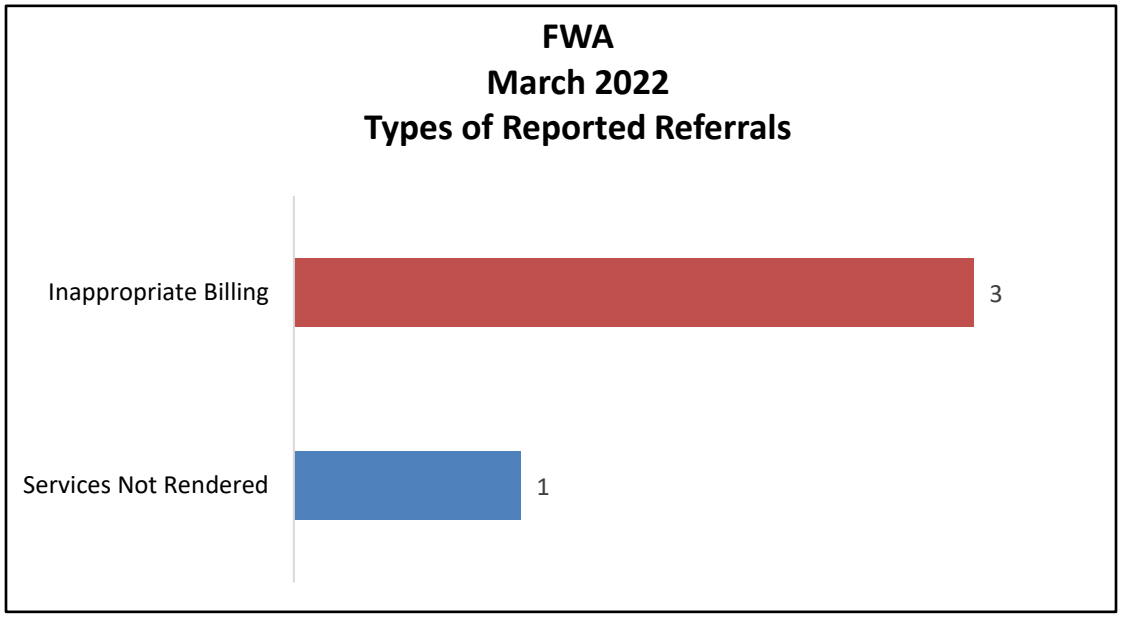
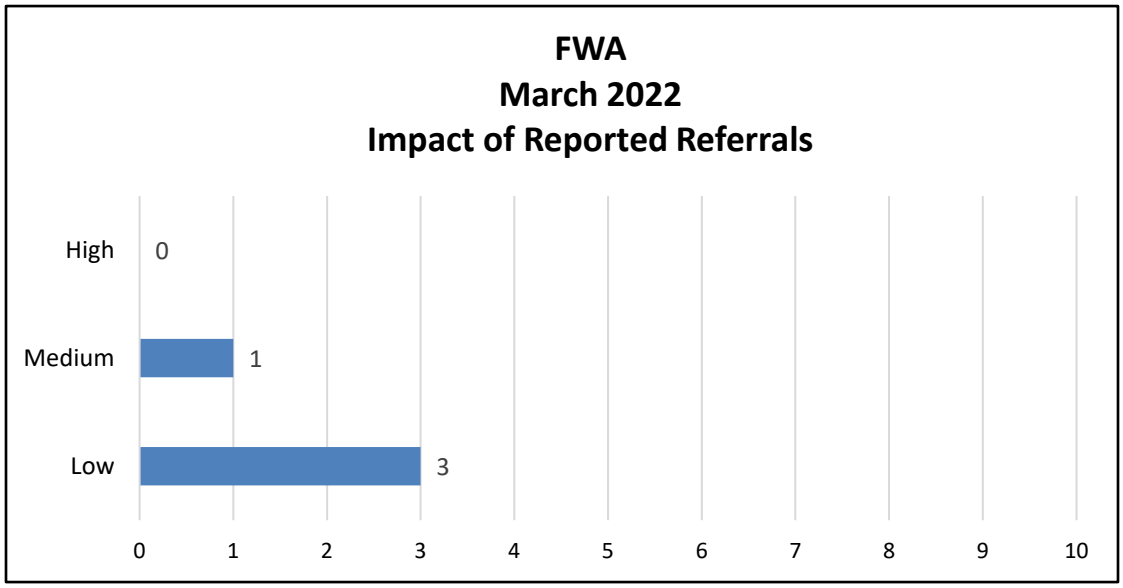
D. Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (March 2022)

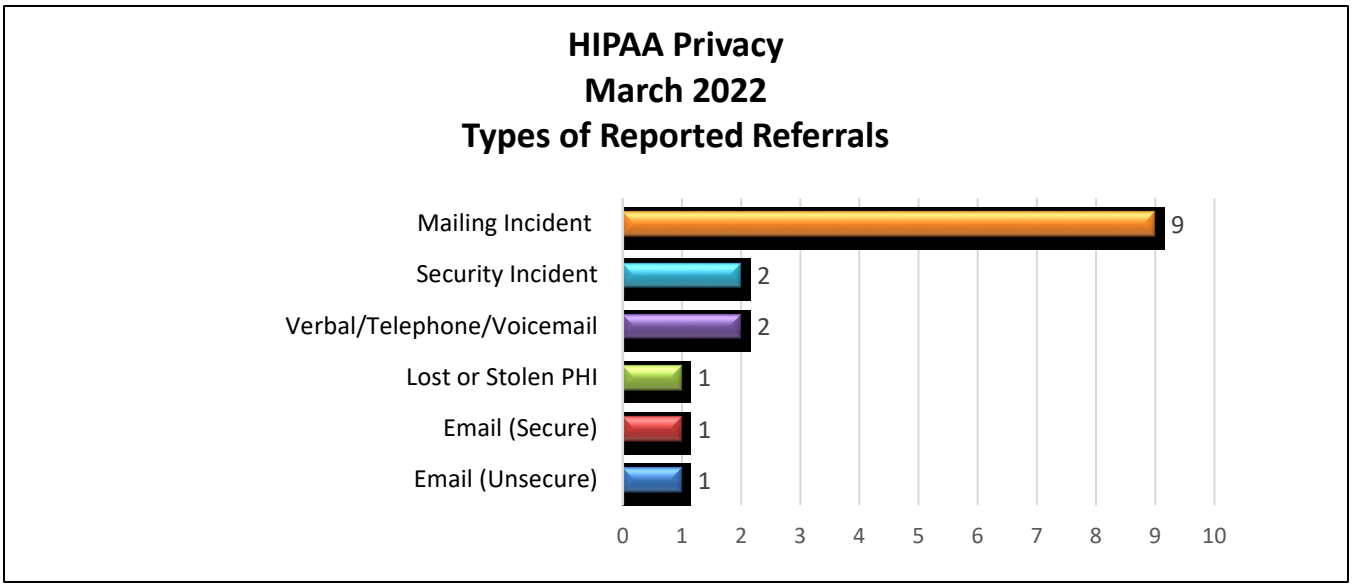


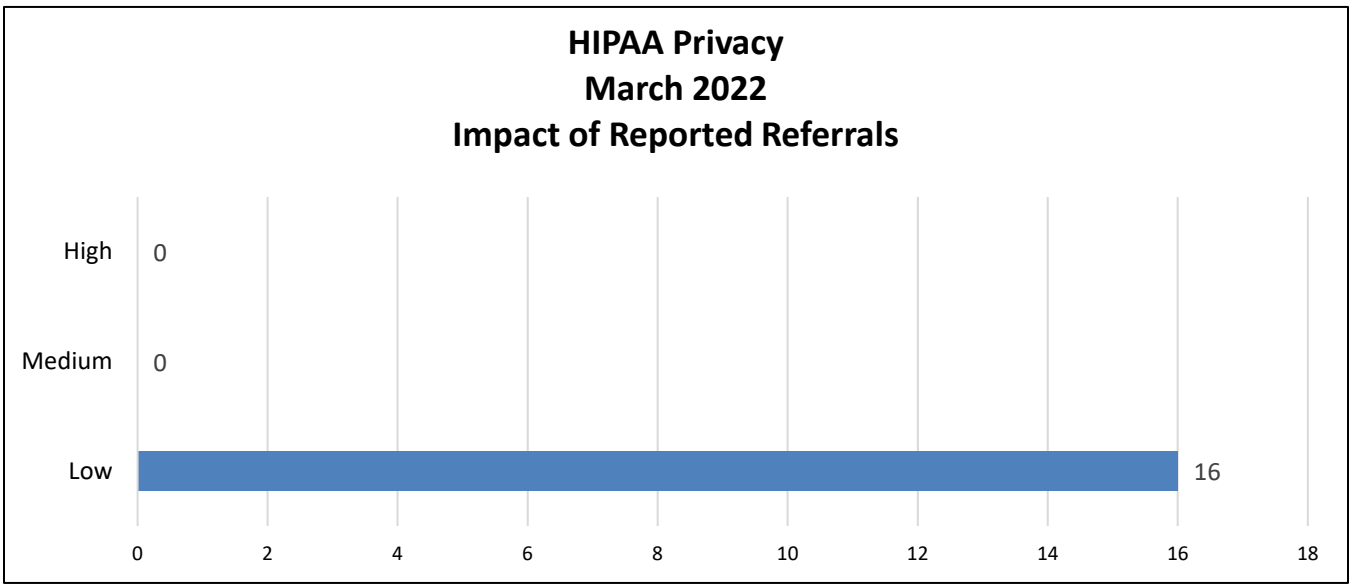


Total Number of New Cases Referred to DHCS (State)	4
Total Number of New Cases Referred to DHCS and CMS*	2

*Effective January 1, 2022, CMS implemented a new portal to report suspicious FWA. Any potential FWA *with impact to Medicare* is reported to both DHCS and CMS at the start of an investigation.

E. Privacy Update: (March 2022)





Total Number of Referrals Reported to DHCS (State)	16
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

April 8, 2022

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: April Board of Directors Report

COVID-19 Supplemental Appropriations Package

On April 4th, a bipartisan group of Senators released the text of an agreement for a $10 billion COVID-19 supplemental appropriations package. Of this, $9.25 billion will be appropriated for the Biomedical Advanced Research and Development Authority (BARDA), of which not less than $5 billion will be used to research, develop, manufacture, produce, purchase, and administer therapeutics. Also, at least $750 million will be used for research and clinical trials for emerging coronavirus variants and to support the sustainment and expansion of vaccine manufacturing capacity. Of particular note, the package does not propose using unspent State and/or Local Relief Funds provided by the American Rescue Plan Act (ARPA) as a pay-for, like the House version did. Instead, the bill is fully offset by repurposing unspent funds from the following stimulus accounts created by ARPA or the CARES Act:

- SBA Shuttered Venues Operators Grants—$1.93 billion
- SBA Economic Injury Disaster Loans—$900 million
- USDA ARP and CARES—$1.6 billion
- Transportation Aviation Manufacturing Jobs Protection Program—$2.31 billion
- Higher Education Emergency Relief Fund—$500 million
- Local Assistance and Tribal Consistency Fund—$887 million
- Treasury State Small Business Credit Initiative—$1.873 billion

Text of the bill can be found here.
Congressional Budget Office score of the bill can be found here.
A one-page summary can be found here.

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FISCAL YEAR 2023 PRESIDENT'S BUDGET

On March 28th, President Biden released his Fiscal Year 2023 (FY23) Budget request. The President's budget requests approximately $1.64 trillion in discretionary appropriations, an increase of 9% over the recently enacted $1.51 trillion FY22 Omnibus spending package. The President's budget request includes $829 billion in nondefense discretionary funding, a 14% increase compared to FY22 enacted level. Defense discretionary spending would receive a 4% boost over the FY 2022 level, totaling $813 billion.

- **Department of Health and Human Services**
  - The President is requesting **$127.3 billion** in discretionary funding for the Department of Health and Human Services (HHS), a $26.9 billion increase from the 2021 enacted level.
  - The budget would invest $5 billion to accelerate innovation through the Advanced Research Projects Agency for Health (ARPA-H) to focus on finding treatments and cures to cancer, dementia, diabetes, and other ailments. It would continue to fund the Cancer Moonshot Initiative, and also continue its work to end the HIV/AIDS epidemic. In addition, the budget would prioritize preparing HHS for future pandemics and seek to advance health security for other biological threats.

The President's budget is also requesting $81.7 billion across multiple agencies for pandemic preparedness, increased telehealth funding, and for HRSA to have regulatory authority over the 340B program. The Departments of Labor, Education, and Defense also all have requests that will directly impact the health care provider community.

The full budget can be found here.
The HHS budget can be found here.
A SHC Summary of Key Provisions can be found here.
Past budgets can be found here.

FISCAL YEAR 2023 APPROPRIATIONS & CONGRESSIONALLY DIRECTED SPENDING

In Congress, the FY23 appropriations process is formally underway. After the release of the President's budget, the House Appropriations Committee began releasing guidance for the "*Community Project Funding*" process, also known as earmarks or Congressional Directed Spending. Community Project Funding (CPF) allows non-federal entities to request funding for projects to meet specific guidelines, usually aligning with pre-existing grant programs (e.g., improvements to a *Main Street elderly services facility* would be eligible under the Transportation-HUD Economic Development Initiative). The guidance for the Labor-Health and Human Services-Education bill is included below.

Labor, Health and Human Services, Education, and Related Agencies

- Community Project Funding Request Guidance
  - Workforce Innovation and Opportunity Act (WIOA) demonstrations

- HRSA Health Facilities Construction and Equipment
- SAMHSA Substance Use and/or Mental Health Services programs
- Administration for Children and Families – Child Abuse Prevention or Social Services demonstration
- Elementary and Secondary Education – Innovation and Improvement

FEMA Confirms It Will Pay for Uninsured Covid Costs

FEMA has confirmed that it would reimburse providers for testing, treating, and vaccinating the uninsured, since HRSA's Provider Relief Fund (PRF) stopped accepting claims for testing and treatment on March 22nd and would stop accepting claims for vaccinations on April 5th. In general, FEMA will fund testing, hospital capacity (including medical care in primary care facilities), and vaccinations. Entities can apply for FEMA funding through the COVID-19 Public Assistance Simplified Application here. Applicants can begin their application by contacting their local, state, tribal nation and territorial emergency management office or visiting grantee.fema.gov. Since the Administration and Congress have yet to reach a deal on additional COVID-19 funding that would permit HRSA's Provider Relief Fund to resume reimbursement for uninsured patients, applying for FEMA's Public Assistance appears to be the best opportunity for being reimbursed for these claims. A full list of reimbursable activities can be found here and here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

April 15, 2022

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

As the Legislature goes into April, policy committee hearings are in full swing. Policy Committees will continue for fiscal bills (bills that have a cost to the state) until April 29. Bills keyed non-fiscal have until May 6 to be heard in policy committee. Following the policy committee deadline, fiscal legislation faces its next hurdle, the fiscal committee deadline on May 20.

Now that case rates are declining, activity in the Legislature has been shifting increasingly towards in-person rather than virtual meetings. Virtual meetings are still occurring, but more legislative staff are working from the "Swing Space" rather than from home, increasing opportunities for in-person lobbying.

Other Bills and Topics of Interest

SB 1342 (Bates) - Older Adult Care Coordination. This bill would authorize counties to create a Multi-Disciplinary Team (MDT) for older adults that would allow county departments and aging services providers to exchange information to improve interagency care coordination and service delivery for older adults and their caregivers.

The bill passed out of the Senate Human Service Committee on April 5 and will be heard in the Senate Judiciary Committee on April 26.

CalOptima submitted a support letter for the bill.

AB 2724 (Arambula) - Kaiser Medi-Cal Contract. We continue to lobby legislators asking that they support amendments to exclude CalOptima and other County Organized Health Systems (COHS) from the bill. AB 2724 is the Governor's no-bid contract allowing Kaiser to directly contract with the State to provide Medi-Cal services. The proposal was originally included in a budget trailer bill. AB 2724 will be heard in the Assembly Health Committee on April 19. We are hopeful we can convince enough legislators to support our proposal to exclude COHS from the bill. However, there is still a concern that the Governor will push his trailer bill language through the budget process. Our goal is to get enough legislators to voice their concerns with the bill so that the Governor is forced to accept our amendments.

Care Court - Concerned with the growing homelessness crisis, the Governor has proposed a very bold plan intended to pull people off the street, evaluate their

conditions, and direct them to needed resources. The plan, called Care Court, has been presented as a concept, but many details are unknown. In theory, people would be removed from the street and held temporarily under the direction of a local court. The person could be held against their will while a mental health evaluation is conducted. Medications may be prescribed, and outcomes evaluated for a short duration to evaluate the individual's mental condition. Meanwhile, appropriate housing resources would be identified.

The goals of Care Court are to get people off the street, sometimes against their will, and identify what resources are needed to keep the person off the street. Also, Care Court is intended to be an alternative to conservatorship, although most believe many of the people who move through Care Court could require conservatorship.

Most of the services provided under Care Court would be delivered by counties. In fact, all counties would be required to provide Care Court services. It is unknown currently how much money the state will provide counties to implement Care Court. Resources will be needed for county courts, behavioral health, housing, and medical services. Again, there are many details that must be resolved. We will report more as further details emerge.

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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 (PRF) — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency (PHE), 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
H.R. 5963 Spanberger (VA) **S. 3611 Shaheen (NH)**	**Provider Relief Fund Improvement Act:** Would delay the deadline by which providers must spend any funds received from the PRF until the end of the COVID-19 PHE. Would also direct HHS to distribute any funds remaining in the PRF by March 31, 2022. Finally, would allow workplace safety improvements as an allowable use of PRF dollars. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**11/12/2021** 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 (SUD) 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 SUD services to CalOptima Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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 SUD. ***Potential CalOptima Impact:*** *Additional member and provider outreach activities by CalOptima staff.*	**01/31/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch
AB 2830 **Bloom** **SB 1338** **Umberg**	**Community Assistance, Recovery, and Empowerment (CARE) Court Program:** Would establish the CARE Court Program to facilitate delivery of mental health and SUD services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capabilities. The program would connect a person in crisis with a court-ordered care plan for up to 12 months, with the option to extend an additional 12 months as a diversion from homelessness, incarceration or conservatorship. Care plans could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. Eligible individuals may be referred by family members, counties, behavioral health providers or first responders among others. ***Potential CalOptima Impact:*** *Increased behavioral health and SUD services for eligible CalOptima Medi-Cal members.*	**02/18/2022** Introduced	CalOptima: Watch
SB 1019 **Gonzalez**	**Mental Health Benefit Outreach and Education:** Would require a Medi-Cal managed care plan (MCP) to conduct annual outreach and education to beneficiaries and primary care physicians regarding covered mental health benefits while incorporating best practices in stigma reduction. DHCS must conduct an annual assessment of Medi-Cal beneficiaries' experience with mental health services, which an MCP must supplement through regional surveys or listening sessions. ***Potential CalOptima Impact:*** *Additional member and provider outreach activities by CalOptima staff.*	**04/06/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch
RN 22 06818 **Trailer Bill**	**Qualifying Community-Based Mobile Crisis Intervention Services:** No sooner than January 1, 2023, and through March 31, 2027, would add 24/7 community-based mobile crisis intervention services as a covered Medi-Cal benefit for beneficiaries experiencing a mental health or SUD crisis. Services would be provided through county behavioral health systems. ***Potential CalOptima Impact:*** *Increased coordination with the Orange County Health Care Agency for behavioral health services; increased follow-up care by CalOptima and its contracted behavioral health providers.*	**03/03/2022** Published by the Department of Finance	CalOptima: Watch

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BUDGET

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2471 DeLauro (CT)	**Consolidated Appropriations Act, 2022:** Appropriates $1.5 trillion to fund the federal government through September 30, 2022, including earmarks for the following projects in Orange County: ■ Children's Hospital of Orange County: $325,000 to expand capacity for mental health treatment services and programs in response to the COVID-19 pandemic ■ City of Huntington Beach: $500,000 to establish a mobile crisis response program ■ County of Orange: $2 million to develop a second Be Well Orange County campus in the City of Irvine ■ County of Orange: $5 million to develop a Coordinated Reentry Center to help justice-involved individuals with mental health conditions or SUDs reintegrate into the community ■ North Orange County Public Safety Task Force: $5 million to expand homeless outreach and housing placement services In addition, extends all current telehealth flexibilities in the Medicare program until approximately five months following the termination of the COVID-19 PHE. ***Potential CalOptima Impact:*** *Increased coordination with the County of Orange and other community partners to support implementation of projects that benefit CalOptima members; continuation of all current telehealth flexibilities for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**03/15/2022** Signed into law	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 PACE.*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
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 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 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 PACE.*	**07/22/2021** Introduced; referred to committees	CalOptima: Watch
AB 1929 **Gabriel**	**Violence Preventive Services:** Would add violence preventive services as a covered Medi-Cal benefit for beneficiaries who have experienced, are at risk of experiencing or have been chronically exposed to community violence, including gunshot wounds, stabbing injuries and other violent harms. DHCS would approve training and certification programs for qualified violence prevention professionals, who would be designated as community health workers (CHWs). ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members; additional credentialing and contracting for a new provider type.*	**04/05/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
AB 1930 **Arambula**	**Perinatal Services:** Would require Medi-Cal coverage of additional perinatal assessments and services as developed by the California Department of Public Health and additional stakeholders for beneficiaries up to one year postpartum. A nonlicensed perinatal worker could deliver such services if supervised by an enrolled Medi-Cal provider or a non-enrolled community-based organization (CBO) if a Medi-Cal provider is available for billing. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members up to one-year postpartum.*	**02/10/2022** Introduced	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2697 **Aguiar-Curry**	**Community Health Workers and Promotores:** Would add preventive services provided by CHWs and promotores as a Medi-Cal covered benefit. Services include health education and navigation for individuals who have or are at risk of a chronic condition or injury and are unable to prevent or manage such condition. Upon implementation, Medi-Cal MCPs would conduct annual benefit education to beneficiaries and providers as well as complete an annual assessment of CHW and promotores capacity and need. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members; additional member and provider outreach activities; additional network adequacy analyses.*	**02/18/2022** Introduced	CalOptima: Watch
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, 2023. In addition, a health plan and its delegated entities 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.*	**03/22/2022** Signed into law	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 covered benefit for CalOptima Medi-Cal members.*	**02/02/2022** Introduced	CalOptima: Watch CAHP: Oppose

MEDI-CAL ELIGIBILITY AND ENROLLMENT

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

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6636 **Trone (MD)** **S. 2697** **Cassidy (LA)**	**Due Process Continuity of Care Act:** Would allow states to extend Medicaid coverage to inmates who are awaiting trial and have not been convicted of a crime. ***Potential CalOptima Impact:*** *If DHCS exercises option and requires enrollment into managed care, increased number of CalOptima Medi-Cal members.*	**08/10/2021** Introduced; referred to committees	CalOptima: Watch
AB 2402 **Rubio, B.**	**Medi-Cal Continuous Eligibility for Children:** Would allow Medi-Cal beneficiaries under five years of age to remain continuously eligible for Medi-Cal regardless of income changes. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**03/29/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
AB 2680 **Arambula**	**Community Health Navigator Program:** Would require DHCS to create the Community Health Navigator Program to issue direct grants to qualified CBOs to conduct targeted outreach, enrollment and access activities for Medi-Cal-eligible individuals and families. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**02/18/2022** Introduced	CalOptima: Watch
RN 22 07748 **Trailer Bill**	**Extend the Duration of Suspension of Medi-Cal Benefits for Adult Incarcerated Individuals:** Would require that Medi-Cal benefits are paused for the entire duration of incarceration without any termination of Medi-Cal eligibility. Current law requires that Medi-Cal benefits are paused for adult inmates for only one year before termination. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members who are recently released from incarceration; improved continuity of care and health outcomes for such members.*	**02/10/2022** Published by the Department of Finance	CalOptima: Watch
RN 22 08022 **Trailer Bill**	**Expansion of Full Scope Medi-Cal Coverage to Individuals 26 to 49 Years of Age, Regardless of Immigration Status:** No sooner than January 1, 2024, would expand eligibility for full-scope Medi-Cal benefits to include individuals ages 26 to 49 years, regardless of immigration status. With previous legislative action extending such eligibility to those under 26 years and over 50 years, this would provide Medi-Cal coverage for all ages regardless of immigration status. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**02/01/2022** Published by the Department of Finance	CalOptima: Watch

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MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1355 **Levine**	**Medi-Cal Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system, effective January 1, 2023, for Medi-Cal services provided through the following: ■ County Drug Medi-Cal Organized Delivery Systems ■ County Mental Health Plans ■ Medi-Cal fee-for-service (FFS) ■ Medi-Cal MCPs without a Knox-Keene license from the California Department of Managed Health Care (DMHC) ■ PACE The proposed DHCS IMR would closely mirror the current DMHC IMR process for Knox-Keene licensed health plans. As a result, the bill would provide every Medi-Cal beneficiary with access to an IMR. ***Potential CalOptima Impact:*** *Implementation of an additional Grievance and Appeals process for CalOptima Medi-Cal and PACE members.*	**01/27/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch
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
AB 1937 **Patterson**	**Out-of-Pocket Pregnancy Costs:** No later than January 1, 2024, would require DHCS to reimburse pregnant Medi-Cal beneficiaries up to $1,250 for out-of-pocket pregnancy costs, including but not limited to birthing classes, midwife and doula care, car seats, cribs, and related items. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members who are currently or were recently pregnant.*	**02/10/2022** Introduced	CalOptima: Watch
AB 1995 **Arambula**	**Medi-Cal Premium and Copayment Elimination:** Would eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% federal poverty level (FPL), working disabled persons with incomes less than 250% FPL and pregnant women and infants enrolled in the Medi-Cal Access Program. Would also eliminate copayments for all Medi-Cal beneficiaries. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members.*	**03/22/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2724 **Arambula** **RN 22 08897** **Trailer Bill**	**Alternate Health Care Service Plan:** No sooner than January 1, 2024, would authorize DHCS to contract directly with an Alternate Health Care Service Plan (AHCSP) as a Medi-Cal MCP in any region. An AHCSP is a nonprofit health plan with at least four million enrollees statewide that owns or operates pharmacies and provides medical services through an exclusive contract with a single medical group in each region. Enrollment into an AHCSP would be limited to the following Medi-Cal beneficiaries: ■ Previous AHCSP enrollees and their immediate family members ■ Dually eligible for Medi-Cal and Medicare benefits ■ Foster youth ***Potential CalOptima Impact:*** *Additional Medi-Cal MCP in Orange County; decreased number of CalOptima Medi-Cal members; increased percentage of CalOptima members who are high-risk.*	**04/19/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	**04/07/2022** CalOptima: Oppose Unless Amended LHPC: Oppose
SB 858 **Wiener**	**Health Plan Civil Penalties:** Would increase the civil penalty amount that 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 CAHP: Oppose
SB 923 **Wiener**	**TGI Inclusive Care Act:** No later than January 1, 2024, would require health plan staff and contracted providers to complete cultural competency 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.*	**04/06/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch CAHP: Oppose Unless Amended
RN 22 08129 **Trailer Bill**	**Copayments in the Medi-Cal Program:** Effective July 1, 2022, would allow DHCS to eliminate copayments for all Medi-Cal beneficiaries. Currently, providers may impose the following copayments on Medi-Cal beneficiaries, except children, foster youth and women receiving pregnancy or postpartum care: ■ $5 copayment for nonemergency services in an emergency department ■ $1 copayment for most outpatient and dental services, except preventive and family planning services ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members.*	**02/17/2022** Published by the Department of Finance	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
RN 22 10705 Trailer Bill	**Reducing Premiums for the Optional Targeted Low-Income Children's Program (OTLICP), 250 Percent Working Disabled Program (WDP), and Children's Health Insurance Program (CHIP):** Effective July 1, 2022, would allow DHCS to eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% FPL, working disabled persons with incomes less than 250% FPL and pregnant women and infants enrolled in the Medi-Cal Access Program. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members in certain aid code categories.*	**03/03/2022** Published by the Department of Finance	CalOptima: Watch

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
H.R. 6770 Dingell (MI) **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 size and/or service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 3626 **Casey**	**PACE Expanded Act:** To increase access to and the affordability of PACE, would allow PACE organizations to set premiums individually for Medicare-only beneficiaries consistent with their health status. Would also allow individuals to enroll in PACE at any time during the month. In addition, would simplify and expedite the process for organizations to apply for the following: ■ New PACE program ■ New centers for an existing PACE program ■ Expanded service area for an existing PACE center Finally, would allow pilot programs to test the PACE model of care with new populations not currently eligible to participate in PACE. ***Potential CalOptima Impact:*** *Increased number of CalOptima PACE participants; expanded eligibility criteria; new premium development procedure; simplified process to establish new PACE centers.*	**02/10/2022** Introduced; referred to committee	CalOptima: Watch NPA: Support
SB 1342 **Bates**	**Older Adult Care Coordination:** Would allow a county and/or an Area Agency on Aging to create a multi-disciplinary team (MDT) for county departments and aging service providers to exchange information about older adults to better address their health and social needs. By eliminating data silos, MDTs could develop coordinated case plans for wraparound services, provide support to caregivers and improve service delivery. ***Potential CalOptima Impact:*** *Participation in Orange County's MDT; improved care coordination for CalOptima's older adult members.*	**04/05/2022** Passed Senate Human Services Committee; referred to Senate Judiciary Committee	**03/29/2022** CalOptima: Support County of Orange: Sponsor

PHARMACY

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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 if the drug was previously covered for the beneficiary by any health plan. 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 CAHP: Oppose
SB 958 **Limón**	**Medication and Patient Safety Act of 2022:** Would prohibit health plans from arranging "brown bagging" or "white bagging": ■ "Brown bagging" involves specialty pharmacies dispensing an infused or injected medication directly to a patient who transports it to a provider for administration. ■ "White bagging" involves specialty pharmacies distributing such medications to a provider ahead of a patient's visit. ***Potential CalOptima Impact:*** *Increased CalOptima costs and decreased member access for certain physician-administered drugs covered by CalOptima.*	**04/18/2022** Rereferred to Senate Appropriations Committee **04/06/2022** Passed Senate Health Committee; referred to Senate Judiciary Committee	CalOptima: Watch CAHP: Oppose

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PROVIDERS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2581 Salas	**Behavioral Health Provider Credentialing:** Effective January 1, 2023, would require health plans to process credentialing applications from mental health and SUD providers within 60 days of receipt. ***Potential CalOptima Impact:*** *Modified provider credentialing processes for Quality Improvement staff.*	**02/18/2022** Introduced	CalOptima: Watch
AB 2659 Patterson	**Midwife Access:** Would require a Medi-Cal MCP to include at least one licensed midwife (LM), certified-nurse midwife (CNM) and alternative birth center specialty clinic in each county within its provider network. An MCP would be exempt if such providers or centers are not located within the county or do not accept Medi-Cal payments. An MCP must reimburse an out-of-network provider who accepts the Medi-Cal FFS rate. ***Potential CalOptima Impact:*** *Additional provider contracting and credentialing; increased access to midwifery services for CalOptima Medi-Cal members.*	**02/18/2022** Introduced	CalOptima: Watch
SB 966 Limón	**Clinic Providers:** Effective 60 days following the termination of the COVID-19 PHE, would allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be reimbursed for visits with an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner. ***Potential CalOptima Impact:*** *Increased member access to behavioral health providers at contracted FQHCs.*	**03/23/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch
SB 987 Portantino	**California Cancer Care Equity Act:** Would require a Medi-Cal MCP to contract directly with at least one National Cancer Institute Designated Cancer Center in each county — where one exists — within the MCP's service area. In addition, an MCP must refer a beneficiary to a Cancer Center within 15 business days of a complex cancer diagnosis, subject to expedited appeals and authorization timelines. An MCP would reimburse a Cancer Center at the Medi-Cal FFS rate. ***Potential CalOptima Impact:*** *Additional provider credentialing and contracting; increased access to cancer care for CalOptima Medi-Cal members.*	**02/14/2022** Introduced	CalOptima: Watch CAHP: Oppose

REIMBURSEMENT RATES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1892 Flora	**California Orthotic and Prosthetic Patient Access and Fairness Act:** Would require reimbursement for prosthetic and orthotic appliances and durable medical equipment (DME) to be at least 80% of the lowest maximum allowance for California established by the federal Medicare program. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to DME providers; adjustment to DHCS capitation rates.*	**04/05/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2458 Weber	**Whole Child Model (WCM) Reimbursement Rates:** Effective January 1, 2023, would increase provider reimbursement rates for WCM services by 25% if provided at a medical practice in which at least 30% of pediatric patients are Medi-Cal beneficiaries. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to WCM providers; adjustment to DHCS capitation rates.*	**03/22/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
RN 22 08446 Trailer Bill	**FQHC Alternative Payment Methodology (APM) Project:** No sooner than January 1, 2024, would authorize DHCS to permanently implement an APM option for FQHCs to receive value-based payments instead of volume-based payments. Specifically, Medi-Cal MCPs would pay an FQHC a per-member-per-month rate, based on historic utilization, which would be no less than the current amount paid through its Prospective Payment System rate. ***Potential CalOptima Impact:*** *New rate structure and modified contracts for CalOptima's contracted FQHCs who participate in the APM project; increased reporting requirements to DHCS.*	**03/07/2022** Published by the Department of Finance	CalOptima: Watch

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
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

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2503 Bustos (IL) **S. 3039 Young (IN)**	**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 (House version) or $10 million (Senate version) 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 PHE and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or 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. 1332 **Carter (GA)** **S. 368** **Scott (SC)**	**Telehealth Modernization Act of 2021:** Would permanently extend certain current telehealth flexibilities in the Medicare program, enacted temporarily in response to the COVID-19 pandemic. Specifically, would permanently allow the following: ■ FQHCs and RHCs may serve as the site of a telehealth provider ■ Beneficiaries may receive all telehealth services at any location, including their own homes ■ CMS may retain and expand the list of covered telehealth services ■ CMS may expand the types of providers eligible to provide telehealth services ***Potential CalOptima Impact:*** *Continuation of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**02/23/2021** Introduced; referred to committees	CalOptima: Watch
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 PHE. ***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 PHE: ■ Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and SUD 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

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
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 PHE. ***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
S. 3593 **Cortez Masto (NV)**	**Telehealth Extension and Evaluation Act:** Would extend current Medicare telehealth payments authorized temporarily in response to the COVID-19 pandemic for two additional years following the termination of the PHE. Would require HHS to study the impact of telehealth flexibilities and report its recommendations for permanent telehealth policies to Congress. ***Potential CalOptima Impact:*** *Continuation of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**02/08/2022** Introduced; referred to committee	CalOptima: Watch
RN 22 09807 **Trailer Bill**	**Medi-Cal Telehealth Services:** Would permanently extend or modify certain Medi-Cal telehealth flexibilities currently authorized during the COVID-19 pandemic as follows: ■ DHCS must specify the Medi-Cal covered benefits that may be delivered via telehealth as well as the telehealth provider types allowed in addition to FQHCs and RHCs. ■ Telehealth services may be delivered via video, audio only, remote patient monitoring and other virtual modalities. ■ Video and audio-only telehealth services must be reimbursed at the same rate as in-person services, while remote patient monitoring and other modalities may be reimbursed at different rates. ■ Medi-Cal providers, including FQHCs and RHCs, may establish a new Medi-Cal patient using video telehealth but not audio-only telehealth or other virtual modalities. Finally, would allow Medi-Cal MCPs to include video telehealth encounters when determining compliance with network adequacy requirements. ***Potential CalOptima Impact:*** *Continuation and modification of certain telehealth flexibilities for CalOptima Medi-Cal.*	**03/08/2022** Published by the Department of Finance	CalOptima: Watch

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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 PHE. ***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)

2021 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)

2021 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

Source: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
May 5, 2022

CalOptima Community Outreach Summary — April and May 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 coalitions, 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 virtually in most instances with some 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 Highlight

CalOptima will host a virtual InfoSeries on the Medi-Cal expansion for community stakeholders and healthcare professionals on Thursday, May 12, from 1:30–2:30 p.m. via Zoom. Beginning May 1, 2022, a new law the Older Adult Expansion in California will offer full scope Medi-Cal to undocumented adults 50 years of age or older who meet eligibility criteria for Medi-Cal. Jamie Peterson and Maria Jaques from the County of Orange Social Services Agency will discuss the Medi-Cal expansion for undocumented adults and the extended postpartum care benefit. Yunkyung Kim, CalOptima's Chief Operating Officer, will discuss how CalOptima is preparing for an increase in CalOptima members. Yunkyung Kim will also highlight CalOptima's maternity health program, Bright Steps.

Summary of Public Activities

As of April 22, CalOptima plans to participate in, organize or convene 59 public activities in April and May. In April, there will be 31 public activities that include 19 virtual community/collaborative meetings, 10 community events, one Cafecito meeting and one Health Network Forum. In May, there will be 28 public activities that include 14 virtual community/collaborative meetings, 13 community events and one Health Network Forum. CalOptima's participation in community events throughout Orange County can be found in the attachment.

Endorsements

CalOptima provided one endorsement since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo) — a letter of support for Illumination Foundation's application for Partnerships for Action: California Health Care & Homelessness Learning Collaborative. 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 in April and May 2022:

April 2022			
4/9 11 a m.–1 p m.	**Spring Fling Health and Resource Fair hosted by Grandma's House of Hope**† The Crossings at Cherry Orchard 2748 W. Lincoln Ave., Anaheim	At least two staff members attended (in-person). Sponsorship fee: $700; included resource table, logo promotion on website and social media channels.	• Health/resource fair • Open to the public
4/9 9 a m.–1 p m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** Golden West College Building 95 (MPR 100) 15751 Gothard St., Huntington Beach	At least 10 staff members attended (in -person).	• Health/resource fair • Open to the public
4/9 9 a m.–Noon	**Health Fair hosted by the Office of Chairman Doug Chaffee**† Melrose Elementary School 974 S. Melrose St., Placentia	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
4/12 6–7 p.m.	**CalFresh Food & Healthy Living Community Presentation (English)*** Virtual	At least three staff members attended.	• Community presentation • Open to the public
4/13 6–7 p.m.	**CalFresh Food & Healthy Living Community Presentation (Spanish)*** Virtual	At least three staff members attended.	• Community presentation • Open to the public
4/14 6–7 p.m.	**CalFresh Food & Healthy Living Community Presentation (Vietnamese)*** Virtual	At least three staff members attended.	• Community presentation • Open to the public
4/15 8 a m.–5 p m.	**Meeting of the Minds Mental Health Conference hosted by Mental Health Association OC**† Anaheim Marriott Hotel 700 W. Convention Way, Anaheim	At least two staff members attended (in-person). Sponsorship fee: $1,000; included resource table, being featured as supporting sponsor in event program and in all media for the event, program acknowledgement on quarter page, CalOptima logo on MHA's website through 2022 and admission for five.	• Health/resource fair • Open to the public
4/16 9 a m.–1 p m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** St. Anthony Claret Catholic Church 1450 E. La Palma Ave., Anaheim	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
4/19 12–4 p.m.	**Resource and Wellness Fair hosted by Jamboree Housing**† Buena Esperanza Apartments 2691 W. La Palma Ave., Anaheim	At least one staff member attended (in-person).	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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4/21 9–11 a m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
4/23 9 a m.–1 p m.	**Vaccine Event hosted by OC 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 attended (in-person).	• Health/resource fair • Open to the public
4/27 9–10:30 a.m.	**Cafecito Meeting*** Virtual	At least three staff members attended.	• Steering committee meeting • Open to collaborative members
May 2022			
5/1 9 a m.–5 p m.	**Aging and Disability Resource Fair hosted by St. Norbert Catholic Church†** St. Norbert Catholic Church 300 E. Taft Ave, Orange	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
5/1 10 a m. – 2p.m	**Health and Wellness Fair hosted by Anaheim Family YMCA†** Anaheim YMCA Community Complex 1422 W. Broadway, Anaheim	At least two staff members to attend (in-person).	• Health/resource fair • Open to the public
5/4 10:30 a.m.–Noon	**Resource Wednesdays hosted by Irvine Unified School District Early Learning Education Center†** Early Childhood Learning Center 1 Smoketree, Irvine	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
5/6 3– 7 p m.	**CalFresh Enrollment Event and Resource Fair*** Delhi Center 505 E. Central Ave., Santa Ana	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public
5/9 4:30 – 5:30 p m.	**Choose Wellness Fair hosted by Garden Grove Unified School District†** Bolsa Grande High School 9401 Westminster Blvd., Garden Grove	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
5/10-5/12 8 a m.– 1:30 p.m.	**Health Literacy Virtual Conference hosted by the Institute for Healthcare Advancement†** Virtual	At least three staff members to attend. Sponsorship fee: $1,000; includes a 30 second promotional video, 1 digital tote bag flyer, logo placement on sponsor page, 1 banner ad and logo placement on conference emails.	• Forum • Open to community stakeholders; register prior to event
5/12 1:00–2:30 p m.	**InfoSeries: Medi-Cal Expansion*** Virtual	At least three staff members to attend.	• Forum • Open to community stakeholders; register prior to event

* CalOptima Hosted
† Exhibitor/Attendee

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5/14 9–11 a m.	**Health and Wellness Resource Fair hosted by OASIS Senior Center†** Oasis Senior Center 801 Narcissus Ave., Corona Del Mar	At least three staff members to attend (in-person).	• Health/resource fair • Open to the public
5/14 9 a m. – 1 p m.	**Spring Health & Resource Fair hosted by the City of Anaheim Active Older Adult Program†** Downtown Anaheim Community Center 250 E. Center St., Anaheim	At least one staff member to attend (in-person). Sponsorship fee: $100 includes a resource table at event.	• Health/resource fair • Open to the public
5/15 10 a m.–4p m.	**Peace of Mind: A Family Wellness Event hosted by Access California Services†** Delhi Center 505 E. Central Ave., Santa Ana	At least one staff member to attend (in-person). Sponsorship fee: $2,000; includes logo on marketing materials, acknowledgment on day of event, virtual background with sponsor logo and resource table at event.	• Health/resource fair • Open to the public
5/19 9 a m.–Noon	**Senior Resource Fair hosted by City of Stanton†** Stanton City Hall 7800 Katella Ave., Stanton	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
5/19 8 a m. – 4:30 p m.	**FaCT Annual Conference hosted by Families and Communities Together†** Great Wolf Lodge 12681 Harbor Blvd., Garden Grove	At least 10 staff members to attend (in-person). Sponsorship fee: $1000; includes group recognition at conference, five event tickets and resource table at event.	• Forum • Open to community stakeholders; register prior to event
5/19 9–11 a m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
5/22 9 a m. – 2 p m.	**Health Fair hosted by St. Joachim Catholic Church†** Saint Joachim Catholic Church & School 1964 Orange Ave., Costa Mesa	At least one staff member to attend.	• 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 Hosted
† Exhibitor/Attendee

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CalOptima Board Action Agenda Referral

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Direct the Chief Executive Officer to Take Actions to Amend CalOptima's Ordinance to Allow for the Participation in the California Health Benefit Exchange

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Support CalOptima's participation in the California Health Benefit Exchange; and
2. Direct the Chief Executive Officer to seek an ordinance change from the County of Orange to allow CalOptima to participate in the State Health Insurance Exchange, also known as, Covered California.

Background/Discussion

The Patient Protection and Affordable Care Act (ACA) was signed into law in March of 2010. The ACA allowed states to set up their own state-based marketplace or exchange to provide its residents with an avenue to shop for and purchase their health insurance and receive discounts in the form of federal subsidies if eligible.

California was the first state to introduce legislation to create the California Health Benefit Exchange, known as Covered California. In September of 2010, then-Governor Arnold Schwarzenegger signed Assembly Bill 1602, (the "California Patient Protection and Affordable Care Act"), by Assembly Speaker John Perez, and Senate Bill 900, by State Senator Elaine Alquist, into law.

In 2011, because of the signed legislations, the Orange County Board of Supervisors voted to not allow CalOptima to participate in Covered California. This was done through amending the CalOptima county ordinance that specifically prohibited CalOptima's participation in the State Health Care Exchange.

Staff is seeking approval to allow the Chief Executive Officer to pursue an ordinance amendment at the County of Orange that would allow CalOptima to participate in Covered California. CalOptima's participation in Covered California would substantially benefit the county and CalOptima members for the following four core reasons:

- Reduce churn by providing CalOptima members continuity of care for former Medi-Cal members.
- Improve access by expanding the options to ensure more lives are covered.
- Extend local expertise that amplifies the impact of CalOptima's community focus.
- Bolster the safety net by bringing revenue that can be invested back into community health.

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If approved, staff will seek approval to change the CalOptima Ordinance in order to allow participation in Covered California. The Ordinance is governed by the Orange County Board of Supervisors, so consideration of a change by the Board of Supervisors would require two readings:

- First Reading: Tuesday, May 10
- Second Reading: Tuesday, May 24

Following that process, CalOptima would begin work on building internal capabilities for a plan launch in January 2024. Covered California plans have an open enrollment period that begins in fall for annual coverage. Thus, the CalOptima plan would need to be ready to offer in late 2023 for 2024. Individuals can enroll outside of this window if they have certain life events, such as loss of coverage, a move, marriage and other considerations.

Fiscal Impact

There is no immediate fiscal impact to support CalOptima's participation in Covered California and to seek a change to CalOptima's ordinance. Staff will address any additional fiscal impact in separate Board actions.

Rationale for Recommendation

Participation in Covered California will provide CalOptima with greater opportunities to further its mission and serve its programs and members. The requested action will initiate the Ordinance change process.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Marketplace Briefing Sheet
2. May 10, 2022 Board of Supervisors Agenda Item

/s/ Michael Hunn — **Authorized Signature**

04/28/2022 — **Date**

Proposal and Timeline

At the May 5th CalOptima Board of Directors meeting, staff will seek approval to change the CalOptima Ordinance at the Board of Supervisors (BoS) in order to allow CalOptima to participate in Covered California. If approved, the ordinance change at the BoS would require two readings:

- First Reading-Tuesday, May 10th
- Second Reading-Tuesday, May 24th

The benefit to CalOptima and our members is:

- Continuity of care: up to 10,000 people in CA move between Medi-Cal and Covered California each month (pre-pandemic). Participating in the Exchange allows CalOptima to maintain continuity of care for Orange County residents who switch coverage
- Improved access to care
- Increased revenue that will help to support the safety net

Background

Medi-Cal offers low-cost or free health coverage to eligible Orange County residents with limited income. Covered California is the state's health insurance marketplace where Orange County residents may shop for health plans and access financial assistance if they qualify for it.

According to Covered California:

- As of December 2021, Orange County has a total of 155,660 residents enrolled in Covered California:
  - 138,470 enrollees are subsidized
  - 17,200 enrollees are unsubsidized

- Covered California Enrollment in Orange County by FPL December 2021

138% FPL or less	2.5%
138% FPL to 150% FPL	22.2%
150% FPL to 200% FPL	23.4%
200% FPL to 250% FPL	13.3%
250% FPL to 400% FPL	25.7%
400% FPL to 600% FPL	5.4%
600% FPL or greater	2.3%

- Enrollment in Orange County by Health Plan, December 2021

Anthem Blue Cross of California	14,310
Blue Shield of California	42,770
Health Net	28,650
Kaiser Permanente	31,650
Molina Healthcare	1,190
Oscar Health Plan of California	37,080

Agenda Item

AGENDA STAFF REPORT

ASR Control 22-000427

MEETING DATE:	05/10/22
LEGAL ENTITY TAKING ACTION:	Board of Supervisors
BOARD OF SUPERVISORS DISTRICT(S):	All Districts
SUBMITTING AGENCY/DEPARTMENT:	Health Care Agency (Approved)
DEPARTMENT CONTACT PERSON(S):	Torhon Barnes (714) 834-5109
	Clayton Chau (714) 834-2830

SUBJECT: Amendments to CalOptima Ordinance

CEO CONCUR	COUNTY COUNSEL REVIEW	CLERK OF THE BOARD
Concur	Approved Ordinance to Form	Discussion 3 Votes Board Majority

Budgeted: N/A **Current Year Cost:** N/A **Annual Cost:** N/A

Staffing Impact: No **# of Positions:** **Sole Source:** N/A

Current Fiscal Year Revenue: N/A

Funding Source: N/A **County Audit in last 3 years:** No

Prior Board Action: 10/18/2011 #29, 10/04/2011 #38

RECOMMENDED ACTION(S):

1. Read title of Ordinance, "An Ordinance of the County of Orange, California amending sections 4-11-2, of the Codified Ordinances of the County of Orange Regarding the Orange County Health Authority."
2. Order further reading of Ordinance be waived.
3. Consider the matter.
4. Direct Ordinance be placed on the agenda for the next regularly scheduled Board of Supervisors meeting for adoption.
5. Consider the matter and adopt the Ordinance at the next regularly scheduled meeting.

SUMMARY:

Modifying the CalOptima Ordinance will allow the CalOptima to participate in the California Health Benefit Exchange.

BACKGROUND INFORMATION:

The Patient Protection and Affordable Care Act (ACA) was signed into law in March of 2010. The ACA allowed states to set up their own state-based marketplace or exchange to provide its residents with an avenue to purchase their health insurance and receive discounts in the form of federal subsidies if eligible.

California was the first state to introduce legislation to create the California Health Benefit Exchange, known as Covered California. In September of 2010, then-Governor Arnold Schwarzenegger signed Assembly Bill 1602, the California Patient Protection and Affordable Care Act and Senate Bill 900 into law.

On October 4, 2011, the Orange County Board of Supervisors amended the CalOptima ordinance that stated, "It is not intended that the Health Authority compete with private sector health plans, individually or through joint ventures, to offer insurance directly to individual or group private payers procuring their coverage in the commercial, non-governmental health care market."

On May 5, 2022, the CalOptima Board of Directors will consider authorizing the CalOptima Chief Executive Officer to seek an amendment of the CalOptima Ordinance from the Board of Supervisors regarding allowing CalOptima to participate in Covered California.

CalOptima's participation in Covered California would substantially benefit the County and CalOptima members for the following four core reasons:

- Reduce churn by providing CalOptima members continuity of care for former Medi-Cal members.
- Improve access by expanding the options to ensure more individuals are covered.
- Extend local expertise that amplifies the impact of CalOptima's community focus.
- Bolster the safety net by bringing revenue that can be invested back into community health.

The proposed amendments authorize CalOptima to participate in the Covered California as a health care service plan in accordance with Title 22 of the California Government Code (commencing with Section 100500) and Title 10 of the California Code of Regulations, and aligns the current Ordinance with Welfare & Institutions Code Section 14087.54.

In the event the Board adopts the amendments, CalOptima plans to begin building internal capabilities for a plan launch in January 2024.

FINANCIAL IMPACT:

N/A

STAFFING IMPACT:

N/A

ATTACHMENT(S):

Attachment A - Proposed Amendments to Orange County Codified Ordinance, Section 4-11-2
Attachment B - Current Version of Orange County Codified Ordinance, Section 4-11-2-2
Attachment C - Welfare & Institutions Code Section 14087.54

ORDINANCE NO. 22-___

AN ORDINANCE OF THE COUNTY OF ORANGE, CALIFORNIA AMENDING SECTIONS 4-11-2 OF THE CODIFIED ORDINANCES OF THE COUNTY OF ORANGE REGARDING THE ORANGE COUNTY HEALTH AUTHORITY

The Board of Supervisors of the County of Orange, California ordains as follows:

SECTION 1. Section 4-11-12 of Article 1 of Division 11 of Title 4 of the Codified Ordinances of the County of Orange is hereby amended to read as follows:

Sec. 4-11-2. - Purpose.

(a) The purpose of the Health Authority is to negotiate exclusive contracts specified in Welfare and Institutions Code section 14087.5 with the California Department of Health Care Services and to arrange for the provision of health care services ~~to qualifying individuals who lack sufficient annual income to meet the cost of healthcare, and whose other assets are so limited that their application toward the cost of health care would jeopardize the person's or family's future minimum self-maintenance and security, pursuant to~~ provided pursuant to chapter 7 of part 3 of division 9 of the Welfare and Institutions Ceode~~, and to participate in any other publicly supported health care program the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. It is not intended that the Health Authority compete with private sector health plans, individually or through joint ventures, to offer insurance directly to individual or group private payers procuring their coverage in the commercial, non-governmental health care market.~~

(b) The Health Authority shall design and operate a program that:

(1) Incorporates managed care concepts; gives high priority to prevention, education and early intervention services; and improves access to primary care and related specialty and ancillary services for enrolled recipients.

(2) Includes mechanisms for assuring that the program is culturally appropriate and linguistically competent, provides for continuity of care and geographic access to health care services, and meets appropriate quality of care standards.

(3) Recognizes the importance of institutions providing medical, nursing and allied health education.

(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system.

(7) Implements a financial plan which includes the creation of a prudent reserve within three (3) years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

(c) The Health Authority shall have the power to contract with providers for services, including, but not limited to, contracts where services are provided on a capitation and other risk-sharing basis. The Health Authority may contract with public and private insurers, purchasers of health insurance, and fiscal intermediaries to administer its health care program.

(d) After commencement of operations of the Health Authority finance program for Medi-Cal recipients, the Health Authority shall design and implement a plan through separate contracts to include within the program it administers those eligible indigent persons for whom the County of Orange is responsible under part 5 (commencing with section 17000) of division 9 of the Welfare and Institutions Code. Unless otherwise provided by the Health Authority, providers contracting with the Health Authority shall serve all CalOptima eligible populations.

(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for the following persons ~~who are eligible to receive medical benefits~~:

(1) Persons who are eligible to receive medical benefits ~~U~~under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).~~;~~

(2) Persons who are eligible to receive medical benefits ~~U~~under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).~~; and~~

(3) ~~As otherwise permitted by Welfare and Institutions Code section 14087.54~~Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The Health Authority shall not use any payment or reserve from the Medi-Cal program for purposes of this subparagraph.

(g) The Health Authority shall have the power to enter into contracts for ~~to~~ provision~~de~~ of~~a~~ health care services~~delivery system for the~~ to individuals in the service area who are eligible to receive medical benefit under any publicly supported program, such as ~~of~~ Medi-Cal ~~eligible,~~ and Healthy Families, if the Health Authority and participating providers acting pursuant to subcontracts with the Health Authority agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the Health Authority does not ensure sufficient funding to cover program costs. The Health Authority shall not use any payments or reserve from the Medi-Cal program for this purpose~~eligible or other low income or indigent people in the County of Orange~~.

(h) The Health Authority shall ~~not~~ have the power to ~~offer a health insurance product in competition with private managed care organizations or private insurance plans in~~ participate in the ~~any~~ California Health ~~Insurance~~ Benefit Exchange (commonly known as Covered California) as a health care service plan in accordance with Title 22 of the California Government Code (commencing with Section 100500) and Title 10 of the California Code of Regulations~~created pursuant to the provisions of California Government Code Sections 100500-100521 or similar statutes that may be enacted, unless that product is intended to serve Medi-Cal eligible, Healthy Families eligible or other low income or indigent persons in obtaining healthcare~~. The Health Authority shall have the power to participate in any other publicly supported health care program that the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. Nothing in this subsection (h) shall be construed to limit the power of the Health Authority to enter into contracts for the programs described in subsections (a) through (g) of this section. Nothing in this subsection (h) shall limit the Health Authority from coordinating the referral of Orange County residents who have applied to a Health ~~Insurance~~ Benefit Exchange and are eligible for enrollment in the Medi-Cal, Healthy Families or other similar programs authorized by state or federal law for low income or indigent persons offered by the Health Authority.

(Ord. No. 3896, § 1, 8-10-93; Ord. No. 98-10, § 1, 7-21-98; Ord. No. 00-8, § 1, 8-1-00; Ord. No. 05-008, § 1, 5-24-05; Ord. No. 06-012, § 1, 12-5-06; Ord. No. 09-001, 1-13-09; Ord. No. 11-013, 5-3-11)

ORANGE COUNTY, CALIFORNIA, CODE OF ORDINANCES
TITLE 4 - HEALTH SANITATION AND ANIMAL REGULATIONS
Division 11 ORANGE COUNTY HEALTH AUTHORITY

ARTICLE 1. GENERAL PROVISIONS

Sec. 4-11-2. - Purpose.

(a) The purpose of the Health Authority is to negotiate exclusive contracts with the California Department of Health Care Services and to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare, and whose other assets are so limited that their application toward the cost of health care would jeopardize the person's or family's future minimum self-maintenance and security, pursuant to chapter 7 of part 3 of division 9 of the Welfare and Institutions code, and to participate in any other publicly supported health care program the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. It is not intended that the Health Authority compete with private sector health plans, individually or through joint ventures, to offer insurance directly to individual or group private payers procuring their coverage in the commercial, non-governmental health care market.

(b) The Health Authority shall design and operate a program that:

(1) Incorporates managed care concepts; gives high priority to prevention, education and early intervention services; and improves access to primary care and related specialty and ancillary services for enrolled recipients.

(2) Includes mechanisms for assuring that the program is culturally appropriate and linguistically competent, provides for continuity of care and geographic access to health care services, and meets appropriate quality of care standards.

(3) Recognizes the importance of institutions providing medical, nursing and allied health education.

(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system.

(7) Implements a financial plan which includes the creation of a prudent reserve within three (3) years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

(c) The Health Authority shall have the power to contract with providers for services, including, but not limited to, contracts where services are provided on a capitation and other risk-sharing basis. The Health Authority may contract with public and private insurers, purchasers of health insurance, and fiscal intermediaries to administer its health care program.

(d) After commencement of operations of the Health Authority finance program for Medi-Cal recipients, the Health Authority shall design and implement a plan through separate contracts to include within the program it administers those eligible indigent persons for whom the County of Orange is responsible under part 5 (commencing with section 17000) of division 9 of the Welfare and Institutions Code. Unless otherwise provided by the Health Authority, providers contracting with the Health Authority shall serve all CalOptima eligible populations.

(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for persons who are eligible to receive medical benefits:

(1) Under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.);

(2) Under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.); and

(3) As otherwise permitted by Welfare and Institutions Code section 14087.54.

(g) The Health Authority shall have the power to contract to provide a health care delivery system for the benefit of Medi-Cal eligible, Healthy Families eligible or other low income or indigent people in the County of Orange.

(h) The Health Authority shall not have the power to offer a health insurance product in competition with private managed care organizations or private insurance plans in any Health Insurance Exchange created pursuant to the provisions of California Government Code Sections 100500-100521 or similar statutes that may be enacted, unless that product is intended to serve

Medi-Cal eligible, Healthy Families eligible or other low income or indigent persons in obtaining healthcare. Nothing in this subsection (h) shall be construed to limit the power of the Health Authority to enter into contracts for the programs described in subsections (a) through (g) of this section. Nothing in this subsection (h) shall limit the Health Authority from coordinating the referral of Orange County residents who have applied to a Health Insurance Exchange and are eligible for enrollment in the Medi-Cal, Healthy Families or other similar programs authorized by state or federal law for low income or indigent persons offered by the Health Authority.

(Ord. No. 3896, § 1, 8-10-93; Ord. No. 98-10, § 1, 7-21-98; Ord. No. 00-8, § 1, 8-1-00; Ord. No. 05-008, § 1, 5-24-05; Ord. No. 06-012, § 1, 12-5-06; Ord. No. 09-001, 1-13-09; Ord. No. 11-013, 5-3-11)

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(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system.

(7) Implements a financial plan which includes the creation of a prudent reserve within three (3) years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

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(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for persons who are eligible to receive medical benefits:

(1) Under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.);

(2) Under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.); and

(3) As otherwise permitted by Welfare and Institutions Code section 14087.54.

(g) The Health Authority shall have the power to contract to provide a health care delivery system for the benefit of Medi-Cal eligible, Healthy Families eligible or other low income or indigent people in the County of Orange.

(h) The Health Authority shall not have the power to offer a health insurance product in competition with private managed care organizations or private insurance plans in any Health Insurance Exchange created pursuant to the provisions of California Government Code Sections 100500-100521 or similar statutes that may be enacted, unless that product is intended to serve

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(Ord. No. 3896, § 1, 8-10-93; Ord. No. 98-10, § 1, 7-21-98; Ord. No. 00-8, § 1, 8-1-00; Ord. No. 05-008, § 1, 5-24-05; Ord. No. 06-012, § 1, 12-5-06; Ord. No. 09-001, 1-13-09; Ord. No. 11-013, 5-3-11)

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.67] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 2.8. County Health Systems [14087.5 - 14087.95] *(Heading of Article 2.8 amended by Stats. 1988, Ch. 1348, Sec. 1.)*

14087.54. (a) Any county or counties may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care in the county or counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) (1) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to "county" shall mean a commission established pursuant to this section.

(2) A commission operating pursuant to this section may also enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under any publicly supported program, if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs. The commission shall not use any payments or reserves from the Medi-Cal program for this purpose.

(3) In addition to the authority specified in paragraph (1), the board of supervisors may, by ordinance, authorize the commission established pursuant to this section to provide health care delivery systems for any or all of the following persons:

(A) Persons who are eligible to receive medical benefits under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(B) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395).

(C) Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The commission shall not use any payment or reserve from the Medi-Cal program for purposes of this subparagraph.

(4) Nothing in this section shall prohibit a commission established pursuant to this section from providing services pursuant to subparagraph (C) of paragraph (3) in counties other than the commission's county if the commission is approved by the Department of Managed Health Care to provide services in those counties. The commission shall not use any payment or reserve from the Medi-Cal program for purposes of this paragraph.

(5) For purposes of providing services to persons described in subparagraph (A) or (B) of paragraph (3), if the commission seeks a contract with the federal Centers for Medicare and Medicaid Services to provide Medicare services as a Medicare Advantage

program, the commission shall first obtain a license under the Knox-Keene Health Care Service Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(6) With respect to the provision of services for persons described in subparagraph (A) or (B) of paragraph (3), the commission shall conform to applicable state licensing and freedom of choice requirements as directed by the federal Centers for Medicare and Medicaid Services.

(7) Any material, provided to a person described in subparagraph (A) or (B) of paragraph (3) who is dually eligible to receive medical benefits under both the Medi-Cal program and the Medicare Program, regarding the enrollment or availability of enrollment in Medicare services established by the commission shall include notice of all of the following information in the following format:

(A) Medi-Cal eligibility will not be lost or otherwise affected if the person does not enroll in the plan for Medicare benefits.

(B) The person is not required to enroll in the Medicare plan to be eligible for Medicare benefits.

(C) The person may have other choices for Medicare coverage and for further assistance may contact the federal Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or www.Medicare.gov.

(D) The notice shall be in plain language, prominently displayed, and translated into any language other than English that the commission is required to use in communicating with Medi-Cal beneficiaries.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at the time that the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Care Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

(j) Nothing in this section shall be construed to supersede Section 14093.06 or 14094.3.

(Amended by Stats. 2007, Ch. 483, Sec. 51. Effective January 1, 2008.)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
21. Approval of Actions Related to Homeless Health Care Initiatives

Contacts
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Katie Balderas, Director, Population Health Management – Interim, (657) 235-6907

Recommended Actions
1) Regarding the Homeless Clinic Access Program (HCAP) Quality Initiative:
    a) Authorize the allocation of up to $700,000 from the restricted Homeless Health Initiatives Reserve to continue funding HCAP provider incentives through December 31, 2022.
2) Regarding the Street Medicine Pilot Program:
    a) Approve the Scope of Work (SOW) for the Street Medicine program.

Background/Discussion
On April 4, 2019, CalOptima's Board of Directors approved $100 million for Homeless Health Initiatives (HHI) to support delivery of care to Medi-Cal members experiencing homelessness. The HCAP is part of HHI and was approved by the Board of Directors in August 2019. Through HCAP, Community Health Centers (CHC) are able to receive an incentive for providing scheduled preventive services at shelters and hotspots.

In April 2020, as COVID-19 continued, CalOptima's Board approved an additional $1 million in funding to expand HCAP services by incentivizing participating CHCs to maintain availability for urgent care, on-call, and telehealth services in collaboration with the Clinical Field Team Pilot Program (CFTPP). In December 2021, CalOptima's Board authorized an extension of CFTPP through the end of 2022 to assess outcomes for members who received services before, during, and after the public health emergency.

On March 17, 2022, CalOptima's Board approved development of a SOW for the Street Medicine program. CalOptima has developed SOW for the Street Medicine program and now presents it for Board approval. Upon Board approval, staff will proceed with finalization and administration of the request for proposals (RFP), which is expected to launch in Summer 2022.

CalOptima requests the Board approve the proposed Street Medicine program SOW. Furthermore, additional funds are needed to sustain HCAP until the RFP process is complete. Therefore, CalOptima also requests the Board approve the allocation of up to $700,000 from the restricted Homeless Health Initiatives Reserve to cover HCAP provider incentives through December 2022 or until the Street Medicine program is implemented, whichever occurs first.

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Fiscal Impact
The recommended action to address the shortfall in the HCAP Quality Initiative through December 31, 2022, has no additional fiscal impact. An allocation of up to $700,000 from the "Clinic health care services in all homeless shelters" category of the Homeless Health Initiatives Reserve approved by the Board on June 27, 2019, will fund this action.

Rationale for Recommendation
CalOptima recognizes the value HCAP participating CHCs bring as they provide vital preventive, urgent care, and on-call services to individuals experiencing homelessness. As staff continue to finalize the Street Medicine RFP, funding is needed for HCAP to maintain service continuity until implementation.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Proposed Street Medicine Scope of Work
3. HCAP Quality Initiative Requirements (revised 4/28/2020)
4. Homeless Health Initiatives 2021 Update

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
2/22/2019	Consider Authorizing Actions Related to Homeless Health Care Delivery, Including, but not limited to, Funding and Provider Contracting		
4/4/2019	Consider Actions Related to Delivery of Care for Homeless CalOptima Members • Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot		$100 million
6/27/2019	Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal ($60 million identified for specific initiatives)		
8/1/2019	Consider Development of a CalOptima Homeless Clinic Access Program for Homeless Health Initiative		$1 million
3/5/2020	Consider Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP pilots through 12/31/2020]	1 year	
4/16/2020	Consider Authorizing Modifications to the CalOptima Homeless Clinic Access Program Homeless Health Initiatives in Response to COVID-19		$1 million
12/3/2020	Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP pilots through 12/31/2021]	1 year	

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Board Meeting Dates	Action	Term	Not to Exceed Amount
12/20/2021	Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP through 12/31/2022]	1 year	

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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Attachment to the May 5, 2022, Board of Directors Meeting – Agenda 21

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Type	Address	City	State	Zip Code
Central City Community Health Center	CFT	2019 Saturn St	Monterey Park	Ca	91755
Families Together of Orange County	CFT	661 W 1st St Suite G	Tustin	CA	92780
Korean Community Services, Inc. dba Korean Community Services Health Center	CFT	7377 La Palma Ave	Buena Park	CA	90622
Serve the People Community Health Center	CFT	1206 E. 17th St., Ste 101	Santa Ana	CA	92701
AltaMed Health Services Corporation	Mobile HC – Fixed Shelter Service	2040 Camfield Ave	Los Angeles	CA	90040
Share Our Selves Corporation	Mobile HC – Fixed Shelter Service	1550 Superior Ave	Costa Mesa	CA	92627
St. Jude Neighborhood Health Centers	Mobile HC – Fixed Shelter Service	731 S Highland Ave	Fullerton	CA	92832
Hurt Family Health Clinic	Mobile HC – Fixed Shelter Service (HCAP participation only)	1100 N Tustin Ave	Santa Ana	CA	92705

Street Medicine Scope of Work Outline

CalOptima is committed to the investment in community health services that will increase the wellness of our street homeless residents. In conjunction with other health partners, we seek to build a continuum of support and linkage to services for those with physical health, behavioral health and substance abuse needs. This will require access to services, from crisis to 24/7 mobile response. Both CalOptima and OC-HCA endeavor to see evidence-based modalities/tools, multi-disciplinary teams to better serve our community, while recognizing that peer services are a best practice model. All services should be welcoming to the people they support and provide an opportunity for a seamless experience linking needs with community resources.

Street Medicine Services may include but are not limited to:

1) Scheduled clinic days via mobile unit or fixed satellite clinic at homeless shelters and homeless service centers (Currently provided through HCAP)
2) Street-based health care for unsheltered individuals that focuses on providing basic and urgent care services at homeless hotspots, including churches, encampments, parks, and other locations.

Key elements of the Street Medicine Program may also include:

1. Geographic Locations of Focus
    a. Scheduled clinic days
        i. Provide services in one or more SPA using a zone-based approach
    b. Street-based health care
        i. Phased approach where the team will deploy to key locations in cities, Spas, encampments, and hotspots.
        ii. Subsequent phases will expand reach based on need
2. Engagement Strategies
    a. Links to the County of Orange for outreach and engagement, mental health and substance use services
    b. Utilize multi-agency case management/conferencing approach with the range of supports driven by acuity
    c. Build trusting relationships using trauma-informed and person-centered approaches
3. Staffing & Deployment Model
    a. Maintain multi-disciplinary teams with outreach workers, medical professionals, behavioral health specialists (as needed and in coordination with Orange County Health Care Agency), and housing specialists. These teams may include:
        i. Dedicated clinical staff such as, but not limited to Nurse Practitioners (NP), Medical Doctor (MD), etc.
        ii. Mental health clinician (e.g. social worker, counselor or psychologist available on an as needed basis)
        iii. Para-clinical staff such as a medical assistant (MA), certified nursing assistant (CNA), emergency medical technician (EMT)
        iv. Must be able to connect with Social Services Agency (SSA) staff to assist with enrollment in Medi-Cal, CalFresh, General Relief, etc.
        v. Must collaborate with other homeless service providers: case manager/personal care coordinators (e.g. OC Outreach & Engagement or

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CalOptima's Homeless Response Team), housing navigators, peer support specialist, community health worker

b. Provide linkage to physical clinic location to serve as medical home with a primary care provider

4. Logistics & Planning
    a. Maintain consistent recurring schedules, on-call availability (and for street-based medicine only, locations and staff)
        i. Availability during both traditional and non-traditional hours, as well as potentially weekends/holidays, as negotiated in final contract
        ii. Capacity to provide coverage for no less than 4 hours in the field on any given day
    b. Provide referrals to specialists ensuring a more holistic approach to care coordination
    c. Provide transportation to and from appointments
    d. In collaboration with CalOptima, develop program materials (e.g. schedules, flyers, etc.)

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Homeless Clinical Access Program (HCAP)
Quality Initiative Requirements

CalOptima strives to provide quality care for our members. This means finding new ways to better serve them. CalOptima is looking for Community Health Centers to coordinate pop -up mobile clinics at designated shelters and hot spots to deliver wrap around services in the area of:

- Preventive Screenings and Chronic Care HEDIS Measures
- Care Coordination Support
- Referral and Follow -up

Criteria for Participation:

- Community Health Centers must have current contracts with CalOptima.
- Community Health Centers should have already fulfilled the contractual requirements for frequency of mobile units at shelters and/or designated hot spots.
- Community Health Centers should focus HCAP program for shelters and/or designated hot spots that meet the following criteria:
    - 50 beds or greater
    - 75 attendees at hot spots (e.g. Mary's Kitchen)
    - Lot large enough for a mobile unit
- Community Health Center are responsible for securing MOUs with the shelters and other locations as applicable. CalOptima can recommend shelters and/or designated hot spots if requested.
- Community Health Centers are expected to submit invoices and claims payment for visits in accordance with CalOptima contractual billing requirements.
    - Submit invoices for Tier 1 Provider Incentive and indicate length of time (4 hours or 8 hours) and name of shelter and/or designated hot spot. Label invoices as HCAP program and fax to CalOptima at **714-796-6613.**
    - Submit claims to CalOptima for preventive services provided to CalOptima members. Please follow CalOptima Medi-Cal claims guidelines with additional criteria below:
        - FL 17 (Name of Referring Provider): CALOPTIMA
        - FL 17b (NP1): 1366702961
        - FL 21 (Primary Diagnosis code): Z59.0; list other diagnosis codes applicable to preventive services (See Attachment A)
        - FL 24b (Place of Service (POS) codes):
            - 15 – Mobile Unit

- Tier 1 Provider Incentive payments will be paid within 30 days of receipt of submitted invoice.
- Tier 2 Provider Incentive payments will be reimbursed quarterly (January, April, July, October).

Tier 1	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Provider Incentive	$800	$1,600

Tier 2	Half Day (4 Hours)	Full Day (8 Hours)
Tier 2 Requirement: Minimum Appointments Required	10 (any combination of services on Attachment A)	20 (any combination of services on Attachment A)
Tier 2 Payout: Claims submission	$400	$800

Attachment A

Preventive Services Billable Code Sets

Measure	Code system	code	Value set name	Definition
Care Coordination/Referral and follow up	CPT	99490	Chronic Care Management	20 minutes of clinical staff time directed by physician or other qualified health care professional per calendar month for patients dealing with: - multiple chronic conditions - chronic conditions placing patient at significant risk of death or acute exacerbation - Comprehensive care plan established, implemented, revised, or monitored
Care Coordination/Referral and follow up	CPT	99487		60 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month for patients dealing with: - multiple chronic conditions - chronic conditions placing patient at significant risk of death or acute exacerbation - Establishment or substantial revision of a comprehensive care plan - Moderate or high complexity medical decision making
AAP	ICD10	Z00.00	Ambulatory Visits	Encounter for general adult medical examination without abnormal findings

AAP	ICD10	Z00.01	Ambulatory Visits	Encounter for general adult medical examination with abnormal findings
BCS	CPT	77063	Mammography	SCREENING DIGITAL BREAST TOMOSYNTHESIS BI
BCS	CPT	77057	Mammography	SCREENING MAMMOGRAPHY BILATERAL
CCS	CPT	88175	Cervical Cytology Lab Test	CYTP C/V AUTO THIN LYR PREPJ SCR MNL RESCR PHYS
CCS	SNOMED	268543007	Cervical Cytology Test Result or Finding	Cancer cervix - screening done (finding)
CCS	CPT	87621	High Risk HPV Lab Test	Nucleic Acid Detection; Papillomavirus, Human, By Amplified Probe
CCS	SNOMED	391147004	High Risk HPV Test Result or Finding	Human papillomavirus test positive (finding)
CCS	SNOMED	391148009	High Risk HPV Test Result or Finding	Human papillomavirus test negative (finding)
CHL	CPT	87110	Chlamydia Test	CULTURE CHLAMYDIA ANY SOURCE
CDC – A1c	CPT	83036	HgbA1c Test	HEMOGLOBIN GLYCOSYLATED A1C
CDC – A1c	CPT II	3046F	HbA1c Level Greater Than 9.0	MOST RECENT HEMOGLOBIN A1C LEVEL >9.0%
CDC – A1c	CPT II	3044F	HbA1c Test Result or Finding	MOST RECENT HEMOGLOBIN A1C LEVEL < 7.0%
CDC – A1c	CPT II	3045F	HbA1c Test Result or Finding	MOST RECENT HEMOGLOBIN A1C LEVEL GT 7.0-9.0 %

CDC - EYE	CPT II	2022F	Diabetic Retinal Screening with Eye Care Professional	DILAT RETINAL EYE EXAM W/INTERP OPHTHAL/OPTOM *May be billed by any provider type in the measurement year
CDC - BP	CPT II	3079F	Diastolic 80-89	MOST RECENT DIASTOLIC BLOOD PRESSURE 80-89 MM HG *Need Diastolic code in conjunction with a Systolic code
CDC - BP	CPT II	3080F	Diastolic Greater Than or Equal To 90	MOST RECENT DIASTOL BLOOD PRES >/EQUAL 90 MM HG *Need Diastolic code in conjunction with a Systolic code
CDC - BP	CPT II	3078F	Diastolic Less Than 80	MOST RECENT DIASTOLIC BLOOD PRESSURE < 80 MM HG *Need Diastolic code in conjunction with a Systolic code
CDC - BP	CPT II	3077F	Systolic Greater Than or Equal To 140	MOST RECENT SYSTOLIC BLOOD PRES>/EQUAL 140 MM HG *Need Systolic code in conjunction with a Diastolic code
CDC - BP	CPT II	3074F	Systolic Less Than 130	MOST RECENT SYSTOLIC BLOOD PRESSURE < 130 MM HG *Need Systolic code in conjunction with a Diastolic code

CDC - BP	CPT II	3075F	Systolic Between 130 To 139	MOST RECENT SYSTOLIC BLOOD PRESS 130-139MM HG *Need Systolic code in conjunction with a Diastolic code

Clinical Field Team (CFT) Incentive Program

Vision

Provide timely, high quality and compassionate care that meets the unique needs of homeless individuals in Orange County

- Professional will provide one or more clinical, field-based team(s) for the entire term of the Pilot which will include (but not be limited to):
    a) Clinical and support staff
    b) Vehicle for transportation of staff and equipment
    c) Medical bag with stethoscope, blood pressure cuff, pulse ox, wound care supplies and other medical supplies as appropriate.
    d) Connection to and use of WPC Connect and CalOptima platforms via iPad/laptop/tablet with internet connectivity
    e) Point of care lab testing: blood glucose, etc. as appropriate
    f) Frequently used medications for immediate dispensation: vaccines, insulin, diabetes medications, antibiotics, Narcan etc.

- Extended hour availability, including on-call services, from 8:30 a.m. to 4:30 p.m., seven days a week coordinated with the CalOptima Homeless Response Team will be provided in rotation with the other Clinical Field Teams. On-call availability may be increased or decreased upon mutual agreement by the parties. If CFT is unable to be available for scheduled on call days and hours, CFT is responsible to identify alternative coverage for the shift and provided CalOptima Homeless Response Team of unavailability, coverage and contact information for alternate.

- Clinical services to be provided by Clinical Field Teams medical personnel consistent with their respective scope of practice include (but are not limited to):
    a) Urgent care: acute infection, cough, UTI, etc.
    b) Wound care
    c) Vaccinations
    d) Health screening
    e) Medication reconciliation and review
    f) Ability to prescribe medications for delivery
    g) eConsults and video consults with specialists via iPad when Medi-Cal covered benefits
    h) PCP and specialist referrals and appointment scheduling
    i) Post discharge/care transitions
    j) Behavioral health care (mild to moderate conditions)
    k) Medical justification for recuperative care
    l) Emergency room referral order (delivered to member)

- Professional may also provide Clinical services in a mobile unit at a hotspot (e.g., shelter, park or soup kitchen) or a fixed location in a shelter on a scheduled basis, as agreed by CalOptima, shelter/operator and Professional. Services shall be provided by medical personnel consistent with their respective scope of practice Primary and Preventive services including but are not limited to services referenced in 3.1.3 a-l above.

- Appropriate referrals and coordination should be made as needed with CalOptima Homeless Response Team, PCP, and Health Network, as appropriate, for the following services:
    a) Behavioral health care (moderate to severe conditions)
    b) Substance use treatment referrals
    c)Recuperative/respite care
    d)Social services and supports
    e) Other community resources

- The services provided under the Clinical Field Team Pilot must include:
    a) In conjunction with the CalOptima Homeless Response Team, coordinate all mobile care services.
    b) Response to calls from CalOptima Homeless Response Team within 45 minutes.

- Reporting. Professional shall provide such information and written reports to CalOptima, DHCS, and HHS, as may be necessary for compliance by CalOptima with its statutory obligations and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

- Clinical Field Team Notes. Professional shall provide such information and written reports to CalOptima, including CFT notes within one business day of the CFT encounter.

COMPENSATION FOR CLINICAL FIELD TEAM SERVICES EFFECTIVE April 1, 2020 THROUGH December 31, 2021

- CalOptima will reimburse Professional for CalOptima Members regardless of Health Network affiliation or primary care provider assignment for Services provided under 3.1.3 or 3.1.4.

- For Medical Services provide by the Clinical Field Team, provided to referred CalOptima eligible Medi-Cal Members, regardless of Health Network affiliation, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or one hundred fifty percent (150.00%) of the Current CalOptima Medi- Cal Fee Schedule on a fee-for-service basis as defined in the CalOptima Policies.

- For Medical Services provide by the Clinical Field Team, provided to referred CalOptima eligible OneCare Connect Members, regardless of Health Network affiliation, CalOptima

shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or one hundred percent (100%) of the current year CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

- For Medical Services provide by the Clinical Field Team, provided to referred CalOptima eligible One Care Members, regardless of Health Network affiliation, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or one hundred percent (100%) of the current year CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

- CalOptima has expanded the Tier 1 Quality Incentive to the Clinical Field Team to support extended availability and on-call services. Clinical Field Teams are expected to submit invoices for Tier 1 Provider Incentive with calendar annotating days and times of extended availability or on-call hours. Label invoices as CFT and fax to CalOptima at **714-796-6613.**

Tier 1	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Provider Incentive	$800	$1,600

Tier 1 Provider Incentive payments will be paid within 30 days of receipt of submitted invoice.

Billing Requirements:

As applicable, Medi-Cal and Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

All claims for services provided by Clinical Field Teams must include the following Diagnosis code, one of the following places of service codes and referring provider.

Place of Service

04 - Homeless Shelter
12 - Home
15 - Mobile Unit
16 - Temporary Lodging
99 - Other Unlisted Facility

Diagnosis

Z59.0 Homelessness

Referring Provider

CalOptima NPI 1366702961

Services with Unestablished Fees:

If a fee has not been established by Medi-Cal or Medicare as applicable, for a procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines.

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Homeless Health Initiatives (HHI) Update

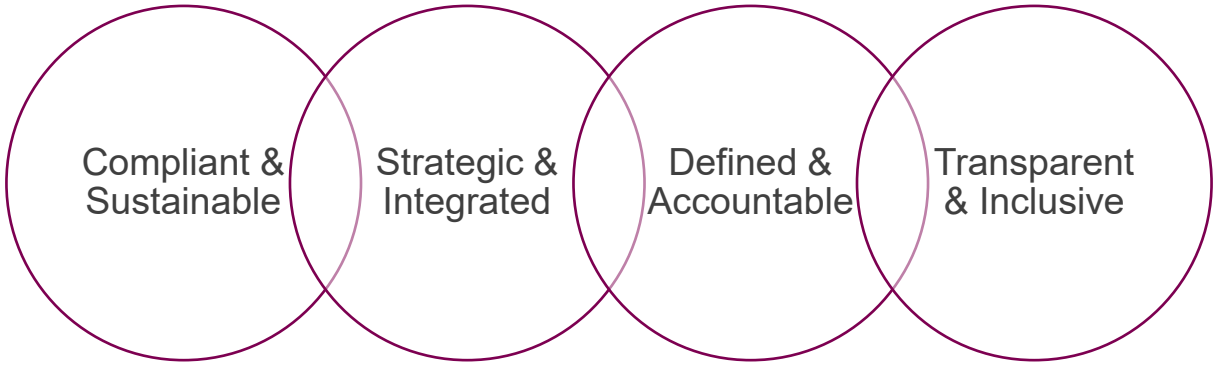
May 5, 2022

Marie Jeannis, Executive Director, Population Health Management and Quality Initiatives

Katie Balderas, Interim Director, Population Health Management

Prior History Leading to HHI

- Goal - Enhance and strengthen the delivery system to better meet the needs of individuals experiencing homelessness
  - March 2019 – Board established an Ad Hoc committee
  - April 2019 – Made $100 million commitment
  - December 2019 – Board adopted HHI Guiding Principles



Funding Allocations

- As March 2022, $51.2 million has been allocated

Be Well OC	Homeless Response Team (HRT)	Clinical Field Teams (CFT) Pilot Program	COVID-19 Vaccination Incentive Program for the Homeless
Homeless Clinic Access Program (HCAP)	Homekey Day Habilitation	Homeless Coordination at Hospitals	Housing for a Healthy California*
Housing Navigation & Support Services*	WPC Recuperative Care	Medical Respite	Street Medicine (new/upcoming)

*Currently no financial impact/not tied to directly to current HHI reserve, though relevant to homeless health

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HHI Drawdown

FUNDS ALLOCATION, APPROVED INITIATIVES:	INITIATIVE SUBTOTALS	UTILIZATION	TOTAL REMAINING	ADDITIONAL DETAILS
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	$244,927 estimated draw down against advanced payment as of February 2022
WPC Recuperative Care	8,250,000	6,011,735	2,238,265	
Medical Respite	250,000	250,000	-	
Day Habilitation (County for Homekey)	2,500,000	2,500,000	-	Draw down expected to begin December 2022
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-	
CalOptima Homeless Response Team	6,000,000	1,275,182	4,724,818	
Homeless Coordination at Hospitals (2% rate adjustment for Medi-Cal classic rates for OC acute care hospitals)	10,000,000	6,778,876	3,221,124	
HHI - PI, QI & CM Support/Staffing	501,087	514,403	(13,316)	HHI support staff
CFT & FQHC Expansion Claims (08/2019 - 12/2021)	300,000	21,290	278,710	
CalOptima Days & QI Program - HCAP and HCAP Expansion	2,000,000	1,823,200	176,800	
COVID-19 Vaccine Incentive Strategy for Members Experiencing Homelessness	400,000	49,599	350,401	Actual amount remaining is approximately $69,000
Funds Allocation Total	**43,201,087**	**32,224,284**	**10,976,803**	

As of February 2022

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Current Priorities

- Enhance data collection and program evaluation
- Formalize HHI-specific communication plan
- Ensure alignment with CalAIM
- Engage members with lived experience and homeless service providers
- Evaluate current initiatives and expand services
- Implement Housing & Homeless Incentive Program (HHIP)*

* Final funding allocation is to be determined

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HHI Outcomes & Data

Program Outcomes

- Utilization change for service dates 4/1/2019-3/31/2021

Service by visit type	HRT *(n=1570)*	CFT *(n=519)*	On-call/FQ Expansion *(n=246)*
Emergency department	**- 17.2%**	**- 8.7%**	**- 1.0%**
Inpatient hospital	**- 31.3%**	**+ 9.3%**	**+ 26.1%**
Primary care	**- 4.5%**	**+ 22.1%**	**+ 46.1%**
Specialist	**+ 15.5%**	**+ 47.8%**	**+ 78.4%**

- Compared visits six months before and six months after HHI service dates
- Members may receive multiple services within the same initiative
- Members may have received services across multiple initiatives
- CFT and HRT count is based on internal tracking; On-call/FQ Expansion (HCAP) is based on Claims submission data, which has been limited

Clinical Field Team (CFT) On-call

- CFT launched in April 2019 to address urgent care needs of those experiencing homelessness
  - 4 clinics provide CFT services
  - Top 5 referral sources: O&E (52%), Courtyard Shelter (8%), City Net (7%), Salvation Army (6%), MHA (5%)
  - Services provided at shelters, street, park, parking lots, encampments, among other locations
  - Most common conditions include wound care, swelling of extremities, medication refills, flu-like symptoms, and skin infestation/rashes

Clinical Field Team (CFT) On-call

- Dispatch data from April 2019-December 2021

	# Calls Dispatched	% of Calls Dispatched	# Treated	% # of Treated
Member*	925	72.9%	817	73.7%
Non-Member	161	12.7%	132	11.9%
Prior Member**	183	14.4%	160	14.4%
Total	**1,269**	**100%**	**1,109**	**100%**

- 269 recuperative care referral recommendations were initiated***
- 39 visits were completed via telehealth

*Includes OneCare, OneCare Connect and Medi-Medi members

**Member was not enrolled at time of CFT on-call visit

***Agency responding to call responsible for follow up on Recuperative Care referrals

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Homeless Response Team

- HRT provides members with case management services and encouraged to actively participate in their treatment to achieve self-sufficiency
  - From April 2019 to December 2021, HRT staff completed 631 outreaches for CFT on-call visits
  - HRT staff have been providing personal care coordination services virtually since April 2020
  - Beginning in August 2021, HRT staff provide regularly scheduled virtual hours at Yale Navigation Center and Costa Mesa Bridge Shelter

Homeless Clinic Access Program

- HCAP began in August 2019
  - Monthly incentive paid to clinics to provide primary and preventive health care at homeless shelters and hotspots
  - Modified in April 2020 to include on-call and telehealth in response to COVID-19
  - Partnered Clinics: Families Together, Korean Community Services, Central City, Serve the People, St. Jude, Share Our Selves, AltaMed, Hurtt
- Data from August 2019 – December 2021

Program Metric*	HCAP (scheduled mobile units)	CFT (on-call and telehealth)
# persons served	6,457	725
# hours scheduled/available	4,476	4,720
# clinics actively providing services	8	4
# of different locations served	32	-

* Data represents what is reported by clinics on invoices submitted to CalOptima

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WPC Recuperative Care & Respite

- County-led pilot focused on improving coordination of physical, behavioral health and social services for members experiencing homelessness

WPC Recuperative Care (8/2018-12/2021)

- Over 1,100 unique members
- 1,574 separate stays
- More than 56,000 days of recuperative care provided
- Average length of stay: 36

Medical Respite (7/2019-7/2020)

- 67 unique members served
- 4,800 days of respite care provided
- Average length of stay: 73

* Services are now offered through CalAIM as Community Supports

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Be Well OC

- $11.4 million advanced payment for Be Well/Mind OC*
  - Nearly $200,000 worth of CalOptima funded services provided during the first year of operation (2/1/2021-12/31/2021)

Sobering Station	• 331 unique members served • 470 bed stays • Average # stays per member: 1.4
Peer Support Services	• 333 Unique members served • Over 56,000 minutes of support provided across 1,362 encounters • Average # minutes per encounter: 42 • Average # minutes of support each member received: 170

* Approved by CalOptima's Board of Directors in May 2019

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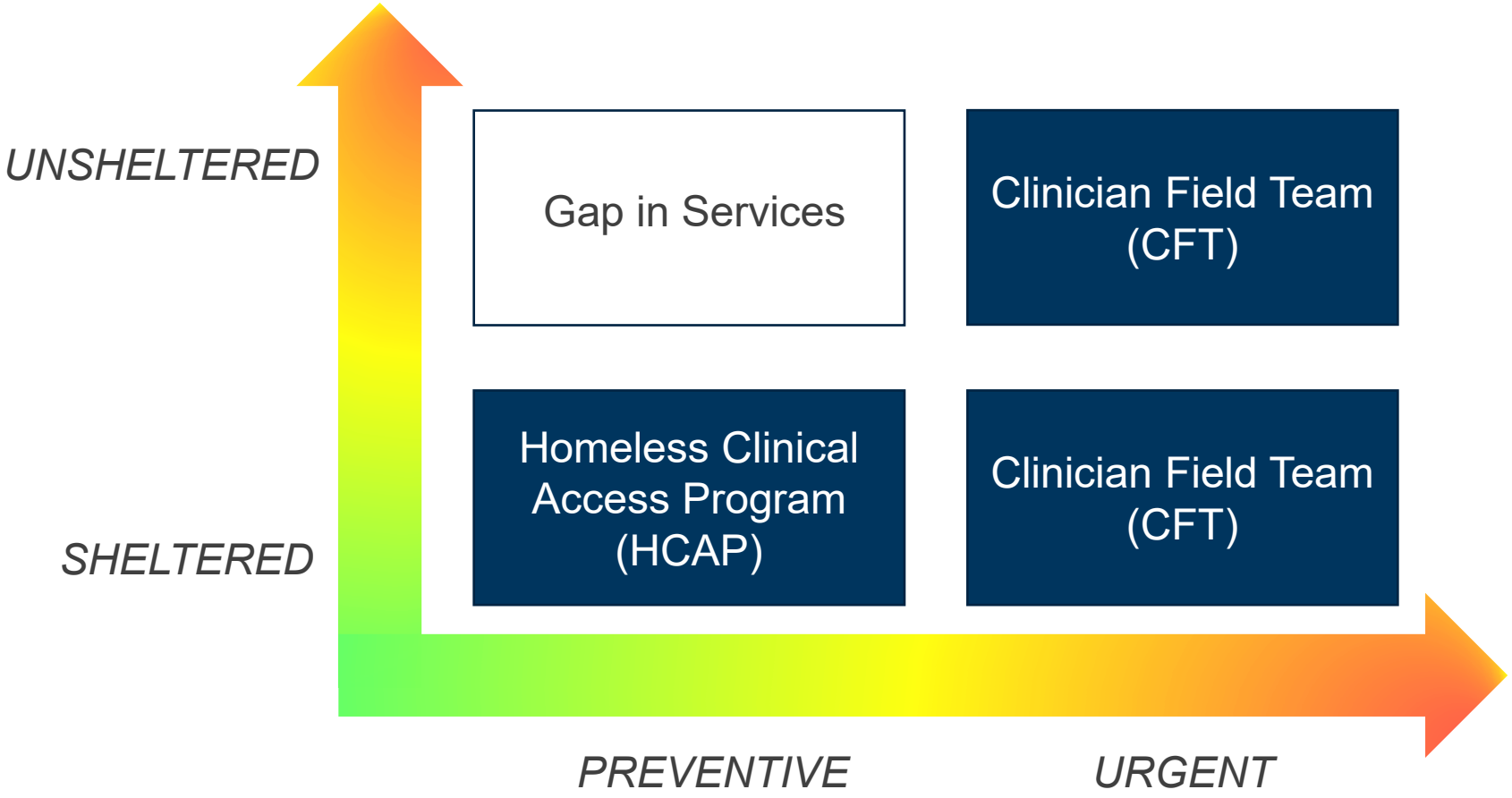
Next Phase

HHI: Current System of Care



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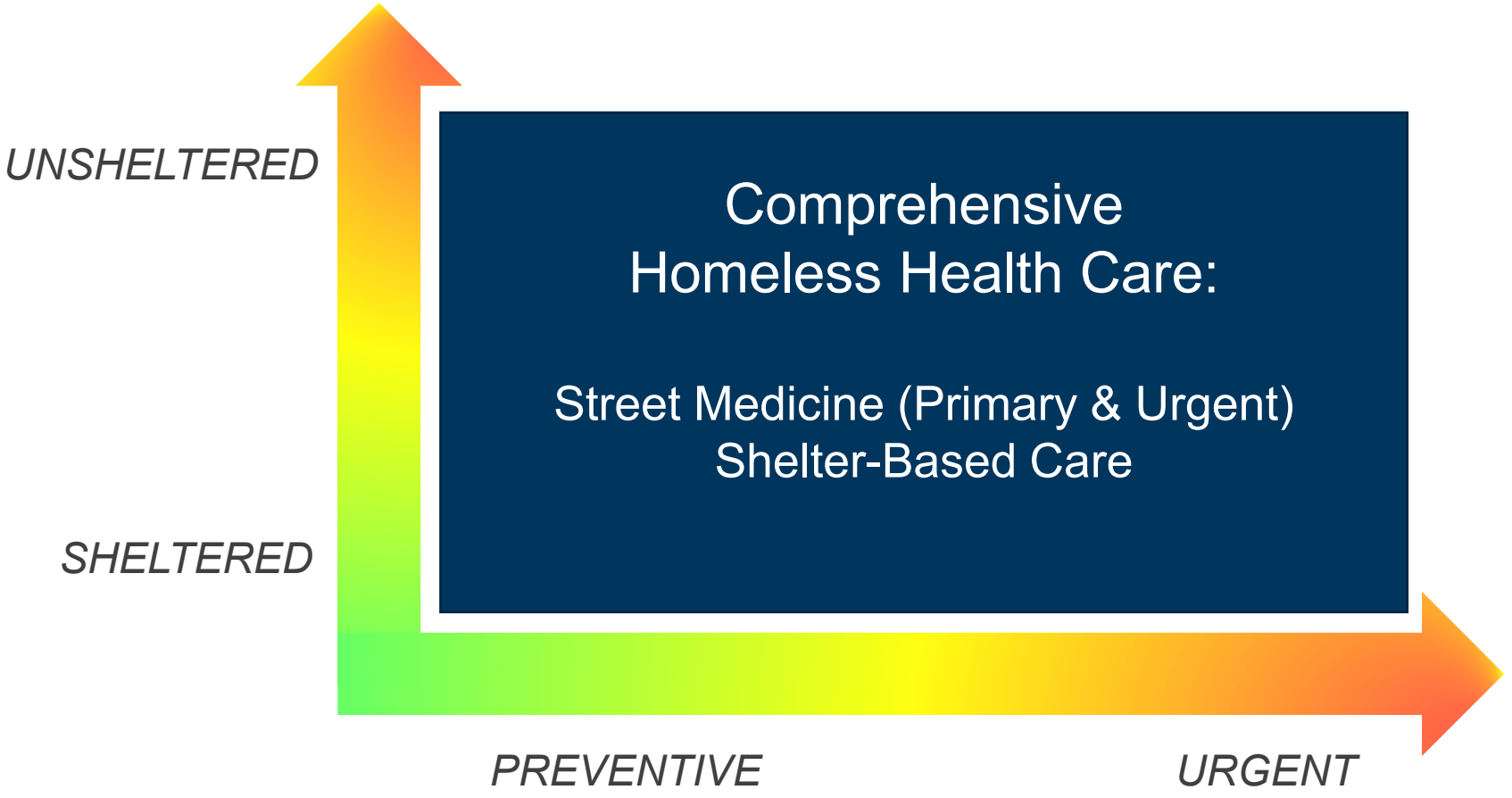
HHI: Proposed System of Care



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Street Medicine: Key Elements

- Providers can participate in one or both pathways:
  - Scheduled clinic days at homeless shelters and hotspots (Currently HCAP)
  - Street-based medical care for unsheltered individuals
    - Urgent Care calls for service (Currently CFT)
    - Regularly scheduled preventive healthcare services
- Engagement Strategies
  - Emphasis on trust building by providing individualized services
  - Basic needs “kits” (e.g. hygiene items, gift cards for food, etc.)
  - Wraparound services using a multi-agency case management approach
  - Utilize a trauma-informed, person-centered approach

Street Medicine: Next Steps

- Finalize scope of work *(pending Board approval)*
  - Includes vetting of proposed payment structure
- Develop and launch Request for Proposals (RFP)
- Evaluate and select vendor(s) to award contract
- Launch Street Medicine program

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Approve the Criteria and Process for CalOptima to Contract with a Provider Organization under a Global Risk Health Maintenance Organization (HMO) Health Network Model

Contact
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions
1. Approve the criteria and process for CalOptima to contract with a health network under a Global Risk Health Maintenance Organization (HMO) model; and
2. Authorize the Chief Executive Officer to approve and implement policies and procedures in accordance with the approved criteria and process.

Background and Discussion
CalOptima utilizes three (3) different contract risk models for delegated health networks: Shared Risk Group (SRG), Physician Hospital Consortia (PHC), and Health Maintenance Organization (HMO). In the SRG model, CalOptima delegates professional risk to a provider organization. Both the PHC and HMO models are full risk models. Under the PHC model, the physician group and hospital are separately contracted and are capitated only for the services delegated to them under their respective contracts. Under the HMO model, a single entity accepts risk for all delegated covered services.

On August 6, 2020, the CalOptima Board of Directors authorized currently participating PHC health networks to change their contract risk model to the HMO model, subject to successfully completing CalOptima's readiness assessment and obtaining appropriate licensure.

Management requests the Board's approval of both the criteria and process for CalOptima to evaluate readiness for existing and future health networks that wish to participate under the HMO model. Staff proposes a three (3)-step process to evaluate prospective full risk health networks:

1. Strategic assessment
2. Independent review and assessment
3. Contract negotiation

For CalOptima to begin consideration of a full risk health network, the applicant must meet the following criteria in support of CalOptima's delivery model of care:

- Support the CalOptima Mission, Vision, and Strategic Priorities;
- Expand members' choice in high quality and equitable health care;
- Promote integrated and member-centered care; and
- Control costs to ensure long-term sustainability of the CalOptima delivery model of care.

Once the applicant meets the criteria, CalOptima will undertake an independent review, by a third party, and assess the applicant. Additionally, if the applicant is in the process of applying for a restricted Knox-

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Keene license, the independent third party will review the critical elements of the applicant's license application including, but not limited to, the following:

  - Summary of the plan and operation (business plan);
  - Service area by zip code;
  - Provider arrangements, including new contracts and network adequacy;
  - Standards of accessibility;
  - Internal quality of care review system(s);
  - Administrative oversight and Management Services Organization (MSO) contracts;
  - Historical financial statements; and
  - Financial projections including feasibility study and tangible net equity (TNE) forecast.
- If the applicant is already licensed to engage in a full risk contract for a non-Medi-Cal product, a review of reports and oversight assessments by the Department of Managed Health Care (DMHC) including the following:
  - Financial information and performance versus peer group;
  - Enforcement actions and responses; and
  - DMHC audit results.
- If the applicant is a current CalOptima health network, a review of the previous 12 months of performance in delegated functions, financial reporting, network adequacy, and overall compliance with existing contract requirements; and
- If the applicant is not a current CalOptima health network, completion of a pre-delegation audit, and review of network overlap.

Finally, CalOptima will proceed to negotiate a contract with a provider organization that has met the following criteria:

- Satisfactorily completes all required assessments;
- Demonstrates financial strength with 200% TNE or at least 150% TNE with an approved plan to close the gap within twenty-four (24) months from the contract effective date;
- If currently licensed by DMHC, has not received any compliance actions by DMHC within the previous twelve (12) months;
- If a current CalOptima health network, it has no open compliance issues; and
- Agrees to comply by all terms of the HMO health network contract.

Management requests the Board to allow CalOptima to implement the criteria and process as outlined, including the creation of ongoing compliance with all necessary policies and procedures. Staff will inform the Board of any risk arrangement changes and will return to the Board with any recommendations on contract amendments related to model changes to existing SRG health networks or new HMO contracts that have met the Board-approved criteria and process.

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Fiscal Impact

The recommended action to approve the criteria and process to contract with a health network under an HMO model is operational in nature with no immediate fiscal impact beyond what is incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

Establishing clear criteria and processes allows CalOptima to consider requests from provider organizations to contract with CalOptima in a full risk capitated and delegated arrangement in a consistent and transparent manner. The proposed criteria and process ensures a fair consideration of the contract model and that any such arrangement that is approved fully supports CalOptima's mission and brings value to CalOptima's members and to the delivery model of care.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Previous Board Action dated August 6, 2020, "Consider Authorizing Contract Model Changes for Physician-Hospital Consortium Health Networks"

/s/ Michael Hunn — *04/28/2022*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize currently participating Physician-Hospital Consortium (PHC) Health Networks to change their contract risk model for the Medi-Cal (MC) line of business to a Health Maintenance Organization (HMO) model, subject to successfully completing CalOptima's readiness assessment and obtaining Department of Managed Health Care (DMHC) licensure; and,
2. Authorize the termination of the Medi-Cal PHC health network current Physician and Hospital contracts to transition the capitated membership to the HMO health network model; and,
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute contracts and/or contract amendments necessary to implement the new HMO model for existing PHC Health Networks that elect to participate in CalOptima's Medi-Cal program under the HMO model.

Background/Discussion

CalOptima utilizes three different contract risk models for its Medi-Cal program, each entailing varying levels of financial risk: Physician Hospital Consortia (PHC), Shared-Risk Group (SRG), and Health Maintenance Organization (HMO). CalOptima currently contracts with three (3) PHC health networks, five (5) SRG Health Networks, and four (4) HMO Health Networks to administer its Medi-Cal program. Both the PHC and HMO models are full risk models. Under the PHC Health Network model, the Physician Group and Hospital in the PHC are separately contracted and are capitated only for the services delegated to them under their respective contracts. Under the HMO model, the HMO is a single entity that may accept risk for all delegated contracted covered services as a DMHC licensed HMO plan.

Staff is recommending the CalOptima Board of Directors consider authorizing the existing PHC Health Networks to convert their risk model to an HMO model if licensed as such by DMHC prospectively. This would allow CalOptima staff to work directly with the PHC Health Networks seeking to change the Medi-Cal contract risk arrangement to an HMO model including the initiation of the readiness assessment. Permission would be required to terminate the PHC network Physician and Hospital contracts as the capitated member enrollment of the PHC moves to an HMO contract model. The HMO could contract with the same PHC network Hospital or other hospitals for inpatient/outpatient hospital services.

If approved, this proposed recommendation would allow existing PHC Health Networks to participate in CalOptima's Medi-Cal program under the HMO contract risk model, provided they meet all regulatory and operational readiness requirements associated with the proposed contracting change. A PHC wishing to convert their contract risk model with CalOptima to HMO would be required to have or

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obtain a minimum Restricted Knox-Keene license, and meet all pre-contracting requirements inclusive of audits to be considered as a CalOptima HMO-contracted Health Network.

Changes to the risk model for Health Networks contracted to participate in the Cal MediConnect ("OneCare Connect") and CalOptima's Dual Eligible Special Needs Plans OneCare program are not addressed in this recommended action given the approaching sunset of the Cal MediConnect program by the Department of Health Care Services (DHCS) in 2022. That transition may require contract risk model changes to ensure consistency for the member's access to services. Additionally, risk model changes for SRG Health Networks contracted to participate in CalOptima's Medi-Cal program will need to be further evaluated to determine the impact to CalOptima as a whole and the complex financial considerations associated with the disruption of the shared risk pools maintained between CalOptima and the contracted SRG Health Networks before staff makes any additional recommendations regarding any other potential risk model transitions.

Fiscal Impact
The recommended action to allow existing PHC Health Networks to convert to an HMO risk model, subject to satisfactorily completing the readiness assessment and obtaining DMHC licensure has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

Rationale for Recommendation
Allowing existing PHC Health Networks to request changes to their Medi-Cal contract risk model from a PHC to HMO model will expand Member access and allow existing PHC Health Networks the flexibility to participate in the CalOptima Medi-Cal program in the preferred contract model which best meets their business needs.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by This Recommended Action

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

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network Inc	600 City Parkway West, Ste. 800	Orange	CA	92868
Children's Hospital of Orange County and CHOC Physicians Network	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming St., Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Authorize Extension and Amendments of CalOptima Health Network and Fee-for-Service Provider Contracts except Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., Talbert Medical Group P.C., and UC Irvine Health

Contact

Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Authorize the CEO to Amend the Medi-Cal Health Network Full-Risk Health Maintenance Organization (HMO)., Shared-Risk Group (SRG), Physician Hospital Consortia Hospital (PHC-H) and Physician Hospital Consortia Physician (PHC-P) contracts, except Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., and Talbert Medical Group P.C., to:
    a. Extend the contract term through June 30, 2027;
    b. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the CalOptima Board of Directors (Board); and
    c. Add language reflecting the provision of arbitration where necessary.
2. Authorize the CEO to amend the Fee-for-Service (FFS) Medi-Cal, OneCare, and OneCare Connect Medical and Non-Medical Ancillary Services, Hospital, and Professional Services contracts, except UC Irvine Health to:
    a. Extend the contract term through June 30, 2027;
    b. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board;
    c. Add language reflecting the provision of arbitration as necessary; and
    d. Add language for termination without cause after 90 days.
3. Authorize the CEO amend the Kaiser Foundation Health Plan, Inc. HMO contract to:
    a. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board, after the expiration of their contract on June 30, 2023; and
    b. Add language reflecting the provision of arbitration as necessary.

Background and Discussion

Staff seeks to amend the above-named contracts to extend them until June 30, 2027, and amend the terms as described below. These providers care for CalOptima's Medi-Cal, OneCare, and OneCare Connect members assigned to CalOptima Direct, SRG, HMO, and PHC networks. The Kaiser Foundation Health Plan Inc. HMO contract term is not set to expire until June 30, 2023, and therefore is not being renewed, however is subject to all other applicable amendments.

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Extension Language

Current language in provider contracts requires annual Board approval for renewal of contracts. New language will be added to reflect:

a) A standard five-year (5) contract extension, and
b) Five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board.

This revision will add operational efficiency and will ensure continuity of member access to care.

Arbitration Language

To expedite resolution of any disputes efficiently, cost-effectively, and avoid disruption of member access to care to the extent possible, arbitration will be the method for dispute resolution. This will avoid the expense and time of litigating contract disputes in Superior Court.

Termination Without Cause

Language was added to allow for either party (CalOptima or provider) to terminate the contract after the initial term, without cause, with 90-days written notice.

To ensure continuity of access to care and support the stability of CalOptima's contracted provider network, staff requests the Board authorize the CEO to execute all proposed amendments of the contract terms, and an amendment to extend the contracts through June 30, 2027, for the above-named contracts.

Fiscal Impact

Management will include expenses associated with the extended contracts in the CalOptima Fiscal Year 2022-23 Operating Budget. There is no additional fiscal impact for the recommended contract language changes.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with its providers, and maintain the stability of CalOptima's contracted provider network.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Board Action

Board Actions

N/A

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Networks & UCI				
Name	**Address**	**City**	**State**	**Zip Code**
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
~~Talbert Medical Group, P.C.~~	~~2175 Park Place~~	~~El Segundo~~	~~CA~~	~~90245~~*
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

**Rev. 5/5/2022*

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Authorize Extension and Amendments of CalOptima Health Network Contracts for ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., Talbert Medical Group P.C., and Fee-for-Service Medi-Cal, OneCare, and OneCare Connect Provider Contracts Except UC Irvine Health

Contact

Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Authorize the CEO to Amend the Medi-Cal Health Network Full-Risk Health Maintenance Organization (HMO) Shared-Risk Group (SRG), Physician Hospital Consortia Hospital (PHC-H) and Physician Hospital Consortia Physician (PHC-P) contracts for ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., and Talbert Medical Group P.C., to:
    a. Extend the contract term through June 30, 2027;
    b. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the CalOptima Board of Directors (Board); and
    c. Add language reflecting the provision of arbitration where necessary.
2. Authorize the CEO to amend the Fee-for-Service (FFS) Medi-Cal, OneCare, and OneCare Connect Medical and Non-Medical Ancillary Services, Hospital, and Professional Services contracts except UC Irvine Health to:
    a. Extend the contract term through June 30, 2027;
    b. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board;
    c. Add language reflecting the provision of arbitration as necessary; and
    d. Add language for termination without cause after 90 days.
3. Authorize the CEO to amend the Kaiser Foundation Health Plan, Inc. HMO contract to:
    a. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board after the expiration of their contract in 2023; and
    b. Add language reflecting the provision of arbitration as necessary

Background and Discussion

Staff seeks to amend the above-named contracts to extend them until June 30, 2027, and amend the terms as described below. These providers care for CalOptima's Medi-Cal, OneCare, and OneCare Connect members assigned to CalOptima Direct, SRG, HMO, and PHC networks. The Kaiser Foundation Health Plan Inc. HMO contract term is not set to expire until June 30, 2023, and therefore is not being renewed, however is subject to all other applicable amendments.

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Extension Language
Current language in provider contracts requires annual Board approval for renewal of contracts. New language will be added to reflect:

a) A standard five-year (5) contract extension, and
b) Five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board

This revision will add operational efficiency and will ensure continuity of member access to care.

Arbitration Language
To expedite resolution of any disputes efficiently, cost-effectively, and avoid disruption of member access to care to the extent possible, arbitration will be the method for dispute resolution. This will avoid the expense and time of litigating contract disputes in Superior Court.

Termination Without Cause
Language was added to allow for either party (CalOptima or provider) to terminate the contract after the initial term, without cause, with 90-days written notice.

To ensure continuity of access to care and support the stability of CalOptima's contracted provider network, staff requests the Board authorize the CEO to execute all proposed amendments of the contract terms, and an amendment to extend the contracts through June 30, 2027, for the above-named contracts.

Fiscal Impact
Management will include expenses associated with the extended contracts in the CalOptima Fiscal Year 2022-23 Operating Budget. There is no additional fiscal impact for the recommended contract language changes.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with its providers, and maintain the stability of CalOptima's contracted provider network.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Entities Covered by this Recommended Board Action

Board Actions
N/A

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Networks & UCI				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Authorize Extension and Amendments of CalOptima Health Network Contracts Except Kaiser Foundation Health Plan Inc. and Provider Contract for UC Irvine Health

Contact

Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Authorize the CEO to Amend the Medi-Cal Health Network Full-Risk Health Maintenance Organization (HMO) Except Kaiser Foundation Health Plan, Inc., Shared-Risk Group (SRG), Physician Hospital Consortia Hospital (PHC-H) and Physician Hospital Consortia Physician (PHC-P) contracts to:
    a. Extend the contract term through June 30, 2027;
    b. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the CalOptima Board of Directors (Board); and
    c. Add language reflecting the provision of arbitration where necessary.
2. Approve Amendments to the Fee-for-Service Medi-Cal, OneCare, and OneCare Connect Professional Services contracts for UC Irvine Health to:
    a. Extend the contract term through June 30, 2027;
    b. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board;
    c. Add language reflecting the provision of arbitration as necessary; and
    d. Add language for termination without cause after 90 days.
3. Authorize the CEO to amend the Kaiser Foundation Health Plan, Inc. HMO contract to:
    a. Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board, after the expiration of their contract in 2023; and
    b. Add language reflecting the provision of arbitration as necessary

Background and Discussion

Staff seeks to amend the above-named contracts to extend them until June 30, 2027, and amend the terms as described below. These providers care for CalOptima's Medi-Cal, OneCare, and OneCare Connect members assigned to CalOptima Direct, SRG, HMO, and PHC networks. The Kaiser Foundation Health Plan Inc. HMO contract term is not set to expire until June 30, 2023, and therefore is not being renewed, however is subject to all other applicable amendments.

Extension Language

Current language in provider contracts requires annual Board approval for renewal of contracts. New language will be added to reflect:

a) A standard five-year (5) contract extension, and
b) Five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board

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. This revision will add operational efficiency and will ensure continuity of member access to care.

Arbitration Language
To expedite resolution of any disputes efficiently, cost-effectively, and avoid disruption of member access to care to the extent possible, arbitration will be the method for dispute resolution. This will avoid the expense and time of litigating contract disputes in Superior Court.

Termination Without Cause
Language was added to allow for either party (CalOptima or provider) to terminate the contract after the initial term, without cause, with 90-days written notice.

To ensure continuity of access to care and support the stability of CalOptima's contracted provider network, staff requests the Board authorize the CEO to execute all proposed amendments of the contract terms, and an amendment to extend the contracts through June 30, 2027, for the above-named contracts.

Fiscal Impact
Management will include expenses associated with the extended contracts in the CalOptima Fiscal Year 2022-23 Operating Budget. There is no additional fiscal impact for the recommended contract language changes.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with its providers, and maintain the stability of CalOptima's contracted provider network.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Entities Covered by this Recommended Board Action

Board Actions
N/A

/s/ Michael Hunn *04/28/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Networks & UCI				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
UCI Irvine Health	101 The City Drive South, Bldg 23	Orange	CA	92868*
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Authorize the Chief Executive Officer to Negotiate, Execute and Implement ZeOmega, Inc. Contract for a Care Management System in Support of CalOptima's Digital Transformation Strategy

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Negotiate and execute the contract with ZeOmega Inc., a health management-payer care management vendor, for an initial term not to exceed five years, with three one-year extension options, exercisable at CalOptima's sole discretion, with each extension option subject to prior Board approval; and
2. Complete implementation and replacement of the existing care management system.

Background

A care management system enables many functional departments to deliver CalOptima's member care programs including Population Health, Appeals, Case Management and Utilization Management.

CalOptima's current care management system contract is with Altruista Health LLC, which became effective April 7, 2014. On March 5, 2020, the Board authorized a three-year extension through April 6, 2024. The extension allowed enough time for CalOptima to adopt and stabilize an upgrade to the existing system and to evaluate whether an RFP should be issued to evaluate the marketplace for comparable solutions. The extension also provided the necessary time to complete the RFP process if warranted. (Referenced on page 173 of Board Meeting notes from March 5, 2020).

The Board requested that CalOptima review the existing care management system's functionality to ensure it can meet all current and future requirements from both the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and the constantly evolving programs and requirements.

On December 10, 2021, CalOptima issued a comprehensive RFP with a scope of work to include current known requirements and plan for a system with flexibility to enhance features and functionality based on regulatory requirements.

Discussion

CalOptima's review committee consisted of stakeholders from all impacted departments. Consistent with CalOptima's procurement process, review of bids, vendor demonstrations, interviews and scoring were conducted to select a vendor. CalOptima received 17 bids from vendors on the RFP, and one was disqualified due to an incomplete RFP response. The approved scoring criteria used was based on five

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points per category, used a weighted average, placing the greatest weight on application functionality, and was as follows:

Criteria	Weighted Average
Vendor Effectiveness	5%
Vendor Preparedness	5%
Vendor Responses to Questions	5%
Care Management Module Functionality	18%
Utilization Management Module Functionality	18%
Appeals and Grievances Module Functionality	18%
Provider Quality Improvement Functionality	18%
Presentation and Demonstration	13%

Based on proposal reviews and two rounds of vendor demonstrations from the top seven vendors, the results for the RFP are as follows:

Vendor	Scores	Ranking
ZeOmega	**3.90**	**1**
Medecision	**3.69**	**2**
Casenet	**3.67**	**3**
MedHOK, Inc.	**3.66**	**4**
AssureCare, LLC	**3.49**	**5**
Keystone Peer Review Organization, Inc. (KEPRO)	**3.48**	**6**
Pegasystems, Inc,	**3.45**	**7**
Vital Data Technology	3.41	8
VirtualHealth	3.22	9
Innovaccer	3.12	10
Altruista Health, LLC	3.09	11
InfoMC	3.05	12
CurePatient, Inc.	2.53	13
Kiriworks, LLC	2.09	14
Cerner State & Local Government Services, Inc	1.99	15
Sargas International LLC	1.66	16

ZeOmega, Inc. was selected as a vendor to provide a comprehensive system to enable CalOptima to enhance its Care Management deliverables based on the review process and the scoring above.

If CalOptima cannot reach agreeable contract terms with ZeOmega Inc., staff recommends that the Board authorize a similar process with an alternate vendor. If neither of these contracting efforts are

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successful, staff will return to the Board with further update and recommendations. CalOptima staff respectfully requests that the Board authorize the CEO to negotiate and execute a contract with ZeOmega Inc. for an initial term not to exceed five years, with three one-year extension options, exercisable at CalOptima's sole discretion. Each extension option will be subject to prior Board approval.

Upon contract execution, staff will begin implementation activities of the new care management system and replacement and termination of the existing care management system. CalOptima anticipates a start in June of 2022 and implementation in one year.

Fiscal Impact
An allocation of up to $11.4 million from the "Application Management" category in the restricted Digital Transformation and Workplace Modernization reserve created by the Board on March 17, 2022, will fund the contract for the initial five-year period.

Rationale for Recommendation
CalOptima recommends selecting ZeOmega, Inc. care management system. CalOptima staff have reviewed and qualified ZeOmega Inc., as it fully integrates the administrative functions, supporting both clinical and social aspects of healthcare, to enhance better member outcomes. Accordingly, staff recommends the Board authorize the CEO to contract with ZeOmega Inc. as a result of the completion of the RFP process as authorized by the Board in March 2020.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Board Action: March 5, 2020, Consider Extension of Altruista Health Contract for Comprehensive Medical Management System.

/s/ Michael Hunn — *04/28/2022*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
ZeOmega, Inc	6200 Tennyson Parkway, Suite 200	Plano	TX	75024

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
9. Consider Extension of Altruista Health Contract for Comprehensive Medical Management System

Contact
Nora Onishi, Director Information Services, (714) 246-8400

Recommended Action(s)
Authorize the Chief Executive Officer (CEO) to:

1. Extend the Altruista contract through April 6, 2024, with the existing terms and conditions; and
2. Authorize payment of maintenance and support fees to Altruista through the contract end-date at currently contracted rates., contingent on a successful and enhanced upgrade being completed as early as possible.

Rev. 2/20/20

Background
Altruista Health is the vendor that supplies CalOptima with its comprehensive medical management solution known as Guiding Care.

At the December 5, 2013 Regular Meeting of the CalOptima Board of Directors, the CEO was authorized to (1) select a vendor through an RFP process for a new comprehensive care management system and (2) contract with the selected vendor for an initial term of three years with five one-year extension options, each extension subject to Board approval.

Through the CalOptima competitive bidding process, the Guiding Care system, from Altruista Health, was ultimately selected as the solution of choice. The contract effective and execution date was April 7, 2014. Implementation began in May of 2014 and CalOptima was live with this new solution on Monday, March 30, 2015.

On March 2, 2017, the CalOptima Board of Directors authorized a one-year extension to April 6, 2018 along with delegating authority to the CEO to execute the four remaining one-year extensions. On December 6, 2018, the Board approved execution of the remaining extension options through April 6, 2021.

Discussion
The medical management system, Guiding Care, is one of the two primary systems used to operate the business of CalOptima. The other is Facets, from Cognizant/TriZetto. These two systems are not only tightly embedded into CalOptima business operations, but tightly integrated from a technology perspective with many other ancillary software solutions. Guiding Care has over thirty technology interfaces that have been custom developed to support the operations.

During calendar year 2020, the Guiding Care system is undergoing a significant upgrade, scheduled to be completed during third quarter. This upgrade is intended to improve existing functionality and enable the use of new functionality.

Typically, it may be time to conduct a Request for Proposal (RFP) process to evaluate the marketplace for comparable solutions. Although the existing contract expires in 2021, the upcoming upgrade is significant enough that an RFP process would be premature at this time. It will be important to stabilize the upgrade before deciding if the Guiding Care system will be sustainable for a longer term or if a replacement should be considered.

For these reasons, staff is requesting approval to extend the contract with Altruista for an additional three years with the same terms, conditions, and rates. This will provide enough time to adopt and stabilize the upgrade and to evaluate whether an RFP should be issued. If so, the three-year extension will also provide the necessary time to complete an RFP process if warranted.

Fiscal Impact
Management will include expenses for the recommended action to extend the Altruista Health contract for comprehensive medical management from April 6, 2021, through April 6, 2024, in future CalOptima operating budgets.

Rationale for Recommendation
The extension will enable operations to continue in a seamless manner.

Concurrence
Gary Crockett, Chief Counsel
David Ramirez, MD, Chief Medical Officer
Board of Directors' Finance and Audit Committee

Attachments
1. Board Action: December 5, 2013, Authorize CEO to Select and Contract with a Vendor for a Medical Management System
2. Board Action: March 2, 2017, Consider Authorizing Extension of Contract with Altruista Health for Comprehensive Medical Management System and Delegating Authority to Exercise Remaining Contract Extension Options
3. Board Action: December 6, 2018, Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VI. F. Authorize the Chief Executive Officer (CEO) to Select and Contract with a Vendor for a Medical Management System

Contact

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

Recommended Actions

Authorize the CEO to:

1. Select a vendor through a Request for Proposal (RFP) process for a comprehensive medical management system that will meet current and anticipated business requirements; and
2. With the assistance of legal counsel, contract with the selected vendor for an initial term not to exceed three years, with five one-year extension options~~, with each option year~~ exercisable at CalOptima's sole discretion, with each extension option subject to prior Board approval.

Amended 12/5/13

Background

On March 4, 2010, following an RFP process, the CalOptima Board of Directors authorized management to engage in negotiations with McKesson, our current medical management system vendor, to enter into a new agreement provided the parties could come to terms agreeable to CalOptima. Staff ultimately closed the RFP and extended the existing contract because it was determined that the industry was moving toward more integrated systems that would combine medical management with CalOptima's core claims processing system. The contract with the current vendor was extended for a three year period through May 18, 2013. On April 4, 2013, the Board authorized staff to further extend the McKesson contract through December 31, 2016. The extension was deemed critical at the time to allow CalOptima to maintain the current medical management system and achieve ICD-10 compliance by the October 1, 2014. Several short term extensions of the McKesson agreement have been implemented as contract negotiations have progressed. The agreement currently expires on December 31, 2013, and negotiations are continuing.

In addition, the Board authorized staff to conduct an overall systems assessment and make recommendations to upgrade current systems or implement new systems as part of the three year strategic plan approved in September 2013.

Discussion

Both the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of the Cal Medi-Connect program. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted from the prior dates shared with the Board. At present, the expected start date for Cal MediConnect is April 1, 2014. In preparation, CalOptima participated in an on-site readiness review July 25-26, 2013 and a subsequent systems readiness review on October 21, 2013.

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As a result of the feedback from the on-site and systems readiness reviews, consistent with Board direction to conduct an overall systems assessment, staff has conducted an evaluation and discussion relative to the capabilities of the current medical management system and whether those capabilities support CalOptima's need for Cal MediConnect and to scale for other products.

In the discussion of the April 4, 2013 Board action authorizing the extension of the McKesson agreement, it was recognized that, with the addition of new programs and member populations, there may clinical needs for additional modules for the existing medical management system. While extending and upgrading the current system is an option, management believes that it is in the best interest of CalOptima to evaluate other alternatives to ensure that we are getting the best value from the medical management solution that is chosen as part of our long term solution set.

In order to minimize member and provider disruption, management proposes to complete the RFP process and select a vendor and initiate implementation as soon as January, 2014. Regardless of the outcome of the RFP process, this timeline should minimize the number of members that would need to be moved from one platform to another, should a different system be selected than the current medical management system. With the impending start date for Cal MediConnect currently set at April 1, 2014, this timing is critical. The length of time it takes to get the system replaced or upgraded will directly correlate with the number of members that have to be potentially converted. Conversions of this nature are complex and best if kept to a minimum.

Fiscal Impact
The financial impact is included in the proposed budget for Cal MediConnect, which will be presented in a separate action.

Rationale for Recommendation
The Cal MediConnect program requires tighter integration between all services that are included in the program. Building a system that fully integrates the administrative and clinical responsibilities for Medi-Cal and Medicare covered services is critical in supporting a reduced opt out rate and achieving better outcomes for our members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

9. Consider Authorizing Extension of Contract with Altruista Health for Comprehensive Medical Management System and Delegating Authority to Exercise Remaining Contract Extension Options

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to exercise a one year extension option to extend the Altruista contract through April 6, 2018;
2. Authorize payment of maintenance and support fees to Altruista through this extension period; and
3. Delegate authority to the CEO to exercise the remaining four individual one year contract extension options and to include related maintenance and support fees in future CalOptima operating budgets as applicable.

Background

Altruista Health is the vendor that supplies CalOptima with its comprehensive medical management solution known as Guiding Care.

At the December 5, 2013 Regular Meeting of the CalOptima Board of Directors, the CEO was authorized to (1) select a vendor through a Request for Proposal (RFP) process for a new comprehensive care management system and (2) contract with the selected vendor for an initial term of three years with five one-year extension options, each extension subject to Board approval (see attached).

Through the CalOptima RFP process, the Guiding Care system from Altruista Health was selected as the solution of choice. The contract effective and execution date was April 7, 2014. Implementation began in May of 2014 and CalOptima was ultimately live with this new solution on March 30, 2015. The initial three-year term expires on April 6, 2017.

Discussion

The medical management system, Guiding Care, is one of the two primary systems used to operate the business of CalOptima. The other is Facets, from Cognizant/TriZetto, used for membership enrollment/eligibility, customer service, benefits administration, provider data management, provider reimbursement, and claims processing. These two systems are not only tightly embedded into CalOptima business operations, but tightly integrated from a technology perspective with many other ancillary software solutions. Guiding Care has 29 technology interfaces that have been custom developed to support the operations. Replacing the most tightly integrated solutions is possible, but requires a substantial investment and can be disruptive to operations.

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With two years of usage, staff does not believe that it would be prudent at this time to consider evaluation of possible replacements for this still new solution.

For these reasons, staff is requesting that the Board delegate the authority to exercise the remaining one-year extension options to the CEO. If each one is exercised, the five one-year extension options would run through April 6, 2022. Based on this timeline, staff will likely evaluate the market with a request for information (RFI) or request for proposal (RFP) process in the first quarter of 2020. This will provide sufficient time to complete solution evaluation, selection, and implementation, should it be determined that a new solution is warranted.

Fiscal Impact
The fiscal impact of this extension is budget neutral. The CalOptima Fiscal Year 2016-17 Operating Budget includes the annual fees for the Altruista solution. Management plans to include anticipated expenses for the recommended contract extension periods on or after July 1, 2017 in future CalOptima Operating Budgets.

Rationale for Recommendation
The extension will enable operations to continue in a seamless manner.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated December 5, 2013, Authorize the Chief Executive Officer (CEO) to Select and Contract with a Vendor for a Medical Management System

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VI. F. Authorize the Chief Executive Officer (CEO) to Select and Contract with a Vendor for a Medical Management System

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

Recommended Actions
Authorize the CEO to:
1. Select a vendor through a Request for Proposal (RFP) process for a comprehensive medical management system that will meet current and anticipated business requirements; and
2. With the assistance of legal counsel, contract with the selected vendor for an initial term not to exceed three years with five one-year extension options, with each option year exercisable at CalOptima's discretion.

Background
On March 4, 2010, following an RFP process, the CalOptima Board of Directors authorized management to engage in negotiations with McKesson, our current medical management system vendor, to enter into a new agreement provided the parties could come to terms agreeable to CalOptima. Staff ultimately closed the RFP and extended the existing contract because it was determined that the industry was moving toward more integrated systems that would combine medical management with CalOptima's core claims processing system. The contract with the current vendor was extended for a three year period through May 18, 2013. On April 4, 2013, the Board authorized staff to further extend the McKesson contract through December 31, 2016. The extension was deemed critical at the time to allow CalOptima to maintain the current medical management system and achieve ICD-10 compliance by the October 1, 2014. Several short term extensions of the McKesson agreement have been implemented as contract negotiations have progressed. The agreement currently expires on December 31, 2013, and negotiations are continuing.

In addition, the Board authorized staff to conduct an overall systems assessment and make recommendations to upgrade current systems or implement new systems as part of the three year strategic plan approved in September 2013.

Discussion
Both the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of the Cal Medi-Connect program. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted from the prior dates shared with the Board. At present, the expected start date for Cal MediConnect is April 1, 2014. In preparation, CalOptima participated in an on-site readiness review July 25-26, 2013 and a subsequent systems readiness review on October 21, 2013.

As a result of the feedback from the on-site and systems readiness reviews, consistent with Board direction to conduct an overall systems assessment, staff has conducted an evaluation and discussion relative to the capabilities of the current medical management system and whether those capabilities support CalOptima's need for Cal MediConnect and to scale for other products.

In the discussion of the April 4, 2013 Board action authorizing the extension of the McKesson agreement, it was recognized that, with the addition of new programs and member populations, there may clinical needs for additional modules for the existing medical management system. While extending and upgrading the current system is an option, management believes that it is in the best interest of CalOptima to evaluate other alternatives to ensure that we are getting the best value from the medical management solution that is chosen as part of our long term solution set.

In order to minimize member and provider disruption, management proposes to complete the RFP process and select a vendor and initiate implementation as soon as January, 2014. Regardless of the outcome of the RFP process, this timeline should minimize the number of members that would need to be moved from one platform to another, should a different system be selected than the current medical management system. With the impending start date for Cal MediConnect currently set at April 1, 2014, this timing is critical. The length of time it takes to get the system replaced or upgraded will directly correlate with the number of members that have to be potentially converted. Conversions of this nature are complex and best if kept to a minimum.

Fiscal Impact
The financial impact is included in the proposed budget for Cal MediConnect, which will be presented in a separate action.

Rationale for Recommendation
The Cal MediConnect program requires tighter integration between all services that are included in the program. Building a system that fully integrates the administrative and clinical responsibilities for Medi-Cal and Medicare covered services is critical in supporting a reduced opt out rate and achieving better outcomes for our members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attachment:
    a. Altruista Guiding Care
    b. Burgess Reimbursement System
    c. Edifecs XEngine
    d. Catalyst Solutions
    e. Medecision
    f. Star MTM
    g. Ansafone
    h. Ceridian Dayforce
    i. Silk Road Open Hire and Wingspan

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attachment, Table 1.

Background

CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems are central to this infrastructure while many other supporting solutions surround the core.

Within the managed care industry, this is standard practice, as no commercially-available single solution meets the demands of the industry for all functions, especially when considering the varying lines of business, government regulations, and the uniqueness of each health plan. The trend over the past ten years or more has been to utilize this approach by using a core administrative processing system surrounded by specialty solutions. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

The two core systems for CalOptima are:

1. Cognizant Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, provider contract reimbursement, and customer service.

2. Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, as well as Appeals & Grievances.

The systems included in this staff recommendation are:

a. Altruista Guiding Care – As mentioned above, this is one of CalOptima's two core systems. CalOptima originally contracted with Altruista in April of 2014 for a term of seven total years, including an initial term and five one-year optional renewal terms extending to 4/6/2021. The system was live as of April 2015. There are two years remaining on the current contract, supporting the decision to recommend approval to extend for those two years, to 4/6/2021. Replacement of this core system was a substantial investment in money and time. It can take years for a core system of this type to fully stabilize. There are additional features yet to be explored, including the Population Health modules. No later than during Fiscal Year (FY) 2019-2020, a Request for Information (RFI) will be issued, primarily to remain informed and evaluate the marketplace for systems of this type, to help determine how long this system will remain or when it may be considered for replacement through a Request for Proposal (RFP) process.

b. Burgess Reimbursement System – This solution provides two key function. One - it enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. Two - it uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing. This system is very tightly integrated within the Facets core system software.

c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency.

d. Catalyst Solutions – This vendor provides essential supplemental maintenance services and support of the Facets system based on their depth of knowledge of Facets and the inner workings of the software.

e. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the new CalOptima Provider Portal.

f. Star MTM – This vendor provides the system and services to support the Pharmacy Medication Therapy Management process required by The Centers for Medicare and Medicaid Services (CMS) for both the OneCare and OneCare Connect lines of business. This process is tightly integrated within the overall administration of CalOptima's pharmacy benefit. An RFP will be issued during FY 2020-2021 to re-evaluate this service.

g. Ansafone – This vendor provides critical services supporting both CalOptima's Customer Service function and the Medical Affairs function. Ansafone provides after-hours call center support for both general customer service calls as well as more specific medical affairs calls. Ansafone also periodically conducts designed member outreach calls, as needed. An RFP for this service will be issued during FY 2018-2019 to evaluate the marketplace and to determine if CalOptima will retain the existing vendor or consider other alternatives.

h. Ceridian Dayforce – This is the primary Human Resources (HR) system handling employee benefits and payroll.

i. Silk Road Open Hire and Wingspan – Open Hire is the current HR applicant tracking and recruitment system. Wingspan is the current performance management system where all CalOptima employee performance evaluations are stored.

These three HR systems are tightly woven into the support and management of the CalOptima employees and are mission-critical for ongoing smooth operations. CalOptima has been on these systems for nearly ten years. During FY2019-20, CalOptima will issue an RFP for these functions to evaluate the marketplace to determine if a replacement is warranted, and if a single comprehensive HR solution can be procured rather than separate systems.

Discussion

The vendors listed in the attached table represent the solutions described above with contracts expiring in 2019 or sooner.

Many of these solutions are tightly embedded/integrated into either Facets and/or Guiding Care or are mission critical to the Human Resources function. Replacing any of these solutions would require a substantial additional investment, time commitment, and significant disruption to operations.

Fiscal Impact

The CalOptima FY 2018-19 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and HR systems through June 30, 2019. Management will include expenses for the recommended contract extension periods on or after July 1, 2019, in future CalOptima Operating Budgets.

Rationale for Recommendation

Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community, and its employees.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed Contract Extensions – Table 1
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

Attachment – Table 1 - Proposed Contract Extensions

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Altruista Health – Guiding Care	Core Care Management Solution	4/6/2014	4/6/2019	4/6/2021	2 years remaining on the original contract	$1,485,000
Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2019	6/30/2022	Tightly Integrated with Facets	$442,162
Edifecs – XEngine	Electronic transaction standardization tool	3/9/2011	12/31/2019	12/31/2021	Tightly Integrated with Facets	$90,000
Catalyst Solutions	Facets Support Services	4/21/2014	12/31/18	6/30/2022	Integral supplemental maintenance services for Facets	$35,000
Medecision – Aerial Care Coordination	Provider Portal (CalOptima Link)	3/23/2011	12/31/2019	12/31/2020	Eventually to be replaced with Provider Portal	$1,560,000
Star MTM	Pharmacy Medication Therapy Management Services	11/1/2014	3/21/2020	3/21/2022	Tightly Integrated into the Pharmacy process. Expect to issue RFP during Fiscal Year 2020-2021.	$156,000
Ephonamation.com, Inc., DBA Ansafone	After hours customer service call center; after hours medical affairs call center; member outreach.	9/1/2016	8/31/2019	8/31/2020	Tightly integrated within Customer Service and Medical Affairs. RFP to be issued during Fiscal Year 2018-2019.	$213,000
Ceridian - Dayforce	The main Human Resources System for Benefits and Payroll	6/29/2008	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$254,000

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Silk Road – Open Hire and Wingspan	Human Resources Support Systems – Performance Management, Applicant Tracking	6/19/2009	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$58,500

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altruista Health, Inc.	11800 Sunrise Valley Dr Suite 1000	Reston	VA	20191
Burgess Group, LLC	1701 Duke St	Alexandria	VA	22314
Edifecs, Inc.	1756 114th Ave SE	Bellevue	WA	98004
Catalyst Solutions, LLC	2353 S Broadway	Denver	CO	80210
Medecision, Inc.	550 E Swedesford Rd Building D, Suite 220	Wayne	PA	19087
Star MTM, LLC DBA Clinical Support Services	701 Seneca St	Buffalo	NY	14210
Ephonamation.com, Inc., DBA Ansafone Communications	145 E Columbine Ave	Santa Ana	CA	92707
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
SilkRoad Technology, Inc.	100 S Wacker Dr Suite 425	Chicago	IL	60606

Regular Meeting of the
CalOptima Board of Directors
May 5, 2022

TO FOLLOW CLOSED SESSION

27. Authorize the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2023 and Execute Contracts with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement

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