NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, DECEMBER 6, 2018
2:00 P.M.

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

BOARD OF DIRECTORS

Paul Yost, M.D., Chair	Dr. Nikan Khatibi, Vice Chair
Ria Berger	Ron DiLuigi
Supervisor Andrew Do	Alexander Nguyen, M.D.
Lee Penrose	Richard Sanchez
J. Scott Schoeffel	Supervisor Michelle Steel

Supervisor Lisa Bartlett, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Suzanne Turf

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to the Clerk of the Board. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Board, it is requested that you state your name for the record. Address the Board as a whole through the Chair. Comments to individual Board Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at (714) 246-8806, at least 72 hours prior to the meeting.

The Board Meeting Agenda and supporting documentation is available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. The Board Meeting Agenda and supporting materials are also available online at www.caloptima.org. Board meeting audio is streamed live at https://caloptima.org/en/AboutUs/BoardMeetingsLive.aspx

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Whole-Child Model Transition Delay
   b. State and Federal Advocate Presentations
   c. Industry Association Leadership
   d. Program of All-Inclusive Care for the Elderly Letters of Support
   e. Cal MediConnect Updates
   f. OneCare Connect Event
   g. 2019 Medi-Cal Audit

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. Minutes
   a. Consider Approving Minutes of the November 1, 2018 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the September 18, 2018 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, and the August 9, 2018 Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

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

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

REPORTS

5. Consider Authorizing Contracts with Out-of-Area Hospitals for the Provision of Services to CalOptima Care Network, CalOptima Direct and Shared Risk Group Members to Facilitate the Payment of Department of Health Care Services Hospital Directed Payments

6. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Secondary Agreements with the California Department of Health Care Services (DHCS) Related to Rate Changes

7. Consider Adoption of Resolution Approving Updated CalOptima 2019 Compliance Plan and Authorize the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

9. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018-19 Capital Budget for the Facets and Cactus Upgrades

10. Consider Extension of Contract Related to CalOptima's Core System, Facets

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

12. Consider Authorizing Amendment of Existing Agreement with University of California, Irvine Health to Extend the Intergovernmental Transfer (IGT) Observation Stay Pilot Program

13. Consider Appointment of CalOptima Board of Directors' Whole-Child Model Family Advisory Committee Chair and Vice Chair

14. Consider Ratification of Expenditures Related to Emergency Repairs for CalOptima Facilities and Approval of Future Expenditures for Acquisition of Audio-Visual Equipment

15. Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members Using Intergovernmental Transfer (IGT) 5 Funds

16. Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds

17. **Acting as the CalOptima Foundation:** Consider Authorization of Actions Related to the Dissolution of the CalOptima Foundation

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

ADVISORY COMMITTEE UPDATES

19. Joint Report of the Member Advisory Committee, OneCare Connect (Medicare-Medicaid Plan) Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee

INFORMATION ITEMS

20. Federal and State Legislative Advocates Reports

21. Whole-Child Model Update

22. Overview of Marketing and Educational Efforts

23. Knox-Keene Update to CalOptima's Contracted Health Networks

24. October 2018 Financial Summary

25. Compliance Report

26. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 Pursuant to Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. One Case: THC-Orange County, Inc. d/b/a Kindred Hospital – Westminster and Southern California Specialty Hospital, Inc., d/b/a Kindred Hospital – Santa Ana v. CalOptima. Orange County Superior Court Case No. 30-2018-00988078-CU-BC-CJC

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, February 7, 2019 at 2:00 p.m.

MEMORANDUM

DATE:	December 6, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Whole-Child Model (WCM) Transition Moves to July 2019
On November 9, the Department of Health Care Services (DHCS) changed the timing of Orange County's transition of the California Children's Service (CCS) program to WCM, delaying it six months to no sooner than July 1, 2019. Based on CalOptima's sizable CCS-eligible member population and the complexity of our delegated delivery system, DHCS officials determined that more time is needed to ensure effective preparation for WCM implementation. Until July, CCS-eligible members in CalOptima will continue to receive CCS services from the county CCS program. On November 21, DHCS released new health network adequacy standards that more explicitly establish the number and type of CCS-paneled providers required for a health network to participate in WCM. Based on these requirements, CalOptima has a number of networks that meet the standard, several very near the goal and a few needing more progress. We immediately informed individual networks of their status and are now working to ensure more networks comply with the new requirements. Health networks not meeting the adequacy standards will not be allowed to participate in July, but they can be included at a later date after they demonstrate compliance. To ensure all members and stakeholders are aware of the revised implementation date, CalOptima initiated a significant communications effort using multiple channels, from mailed notices and a call campaign for members to emails and meetings for providers and networks. Overall, CalOptima understands and shares the state's interest in a successful transition that fulfills the original goal — integrating CCS services into Medi-Cal managed care to deliver an improved member experience and more coordinated health care that meets the needs of the whole child.

State and Federal Advocates to Discuss Midterm Elections, Mega Reg
At the December 6 Board meeting, CalOptima's state and federal advocates will provide information about the impact of the midterm elections and other regulatory changes. Don Gilbert from Edelstein Gilbert Robson and Smith will discuss Orange County's state delegation, while Eli Tomar and Geoff Verhoff from Akin Gump will detail the shift in representation at the federal level. Akin Gump is also closely monitoring upcoming revisions to the Mega Reg, the sweeping federal rule affecting Medicaid. Tomar and Verhoff will provide an impact analysis for CalOptima and share their advocacy work alongside industry associations to prepare comments on the changes by the January 2019 deadline.

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CalOptima Represented at the Top Levels of Key Industry Associations
Having access to industry association resources at a higher level will ensure CalOptima has an even greater voice and influence with policymakers. To that end, my role in three associations will be expanding. I was elected to the Board of Directors for America's Health Insurance Plans (AHIP), effective November 13. Combining public and commercial plans, AHIP is the nation's leading voice for health insurers. For Local Health Plans of California, I have moved from my role as vice chair to chair for a two-year term. Finally, on behalf of the Association for Community Affiliated Plans, I was approved as a member of the executive committee and will chair the Medicaid Policy committee on behalf of the 73 member plans for the next two years.

Program of All-Inclusive Care for the Elderly (PACE) Letter of Support Process Open
CalOptima is spreading awareness of the process for an independent PACE organization (PO) to request a letter of support, which is needed so the PO can apply to operate a PACE program in Orange County. CalOptima notified providers in a November fax blast and offered information to CalPACE, an association of PACE organizations in California. Further, we created a new page for our website and shared the link widely, including with the National PACE Association. The window to request a letter is from November 1, 2018–January 31, 2019.

Federal Regulator Considers Three-Year Extension for Cal MediConnect Program
In a November call with the Centers for Medicare & Medicaid Services (CMS), DHCS and Cal MediConnect plans, including CalOptima's OneCare Connect (OCC), learned that the federal regulator is exploring updates to the demonstration program, which are in draft form and subject to review. First is the possibility of extending Cal MediConnect beyond the December 31, 2019, end date for three years to 2022. During the extension period, CMS stated that it would likely increase the quality withhold to 4 percent rather than the current 3 percent, thus putting the plans at further risk. Also, CMS is considering a retrospective financial penalty on plans for high disenrollment rates. Finally, an experience rebate may be offered to plans as a profit-sharing mechanism if a plan achieves certain levels of cost savings. Again, these proposals are in the early stages, and health plan associations are organizing written feedback to CMS.

CalOptima Participates in Busy Medicare Marketplace With OCC Event
December is the height of open enrollment season for Medicare, and CalOptima's dual eligible members are likely receiving many messages and materials regarding enrollment in a Medicare Advantage plan. To engage our current OCC members and attract new ones, CalOptima held our first OCC Member Retention/Outreach Event at Delhi Community Center in November. We invited all OCC members as well as dual eligibles in concentrated Medi-Medi ZIP codes. Attendance at the event was good, with approximately 100 current and prospective members gathered to hear about 2019 benefits in a presentation by Maria Wahab, member outreach and education manager. This was followed by a Q&A session with CalOptima panelists specializing in customer service, pharmacy, case management and more. In addition, attendees had an opportunity to visit resource tables staffed by our health networks, vendors and community-based organizations. Based on this success, we will repeat the event next month.

Preparations Begin for Upcoming Medi-Cal Audit in February 2019
CalOptima's annual routine medical audit of Medi-Cal has been scheduled. DHCS will be on-site February 4–15, 2019, to review our compliance with contractual and regulatory requirements during the period of February 1, 2018, to January 31, 2019.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

November 1, 2018

A Regular Meeting of the CalOptima Board of Directors was held on November 1, 2018, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Director Nguyen led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ria Berger, Ron DiLuigi, Supervisor Andrew Do (at 2:02 p.m.), Alexander Nguyen, M.D., Lee Penrose, Richard Sanchez (at 2:07 p.m.), Scott Schoeffel, Supervisor Michelle Steel

Members Absent: All members present

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

Chair Yost announced the following change to the agenda: Agenda Item 22, Joint Report of the Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee, will follow consideration of the Consent Calendar.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader introduced David Ramirez, M.D., CalOptima's new Chief Medical Officer. Mr. Schrader also provided updates on the January 1, 2019 implementation of the Whole-Child Model, CalOptima's partnership with the Hospital Association of Southern California to address the state's implementation of the private hospital directed payment program, and the process for independent Program of All-Inclusive Care for the Elderly (PACE) organizations to request a letter of support.

An update was provided on proposed Knox-Keene health plan licensing regulations, as well as CalOptima's quality care ad campaign. After discussion of these items, the Board directed staff to provide updated information at the December Board meeting on the Knox-Keene licensure regulations as well as information on CalOptima's current marketing and member education and outreach efforts.

PUBLIC COMMENT

1. Paul Sarode, M.D., Noble Community Medical Associates; Phuc Nguyen, M.D., Reginald Abraham, M.D. Family Choice Medical Group – Oral re: Agenda Item 3, Consider Changes to the Member Auto-Assignment Limits for the CalOptima Community Network.

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2. Paul Sarode, M.D., Noble Community Medical Associates; Bill Barcellona, America's Physician Groups; Reginald Abraham, M.D., Family Choice Medical Group – Oral re: Agenda Item 4, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work.

CONSENT CALENDAR

2. Consider Approving Minutes of the October 4, 2018 Regular Meeting of the CalOptima Board of Directors

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

Chair Yost reordered the agenda to hear Agenda Item 22, Joint Report of the Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee.

ADVISORY COMMITTEE UPDATES

22. Joint Report of the Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee

Sally Molnar, Member Advisory Committee (MAC) Chair, and John Nishimoto, O.D., Provider Advisory Committee (PAC) Chair, reported on the joint meeting of the MAC, OneCare Connect Member Advisory Committee, and the PAC held on October 11, 2018. As requested by the Board of Directors at its September 6, 2018 meeting, the Committees had extensive discussions on the proposed evaluation of CalOptima's delivery system and the lifting of the CalOptima Community Network (CCN) auto-assignment cap, It was reported that the Committees unanimously recommended against the proposal of hiring a consultant and conducting an evaluation of CalOptima's delivery system citing the lack of clear estimates of cost, the need for staff to focus on the implementation of upcoming initiatives, and the effectiveness of the current delivery system. The Committees also unanimously recommended against modifying the existing cap on CCN auto-assignment noting that members have the option of selecting their preferred network and primary care provider upon eligibility for CalOptima and have the option of changing providers and/or networks each month.

REPORTS

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

After considerable discussion and receiving public comment on the recommended action to consider authorizing removal of the 10% auto-assignment limit for the CalOptima Community Network (CCN), and revise Policy EE.1106: Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment to reflect such changes, the Board postponed consideration of this item indefinitely and removed this item from the agenda.

Action: ***On motion of Supervisor Do, seconded and carried, the Board postponed consideration of this item indefinitely; this item was removed from the agenda. (Motion carried 9-0-0)***

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4. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work

After considerable discussion of the recommendations to authorize the Chief Executive Officer to issue a Request for Proposal (RFP) for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system, and to approve the related attached Scope of Work (SOW), Supervisor Do recommended adding two additional items to the SOW: survey to include other County Organized Health Systems, Local Initiative plans, as well as other successful models of integrated managed care delivery systems throughout the country; and consider information from the CalOptima Member Health Needs Assessment that may impact the network delivery system.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer to issue a Request for Proposal for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system; and approved the related attached Scope of Work as revised. (Motion carried 7-2-0; Chair Yost and Director Penrose voting no)***

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

Michelle Laughlin, Network Operations Executive Director, presented the recommended actions related to the requirement that all contracted providers be enrolled in the Medi-Cal program through the Department of Health Care Services by January 1, 2019: 1) Authorize CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019, subject to CalOptima's receipt of proof that each such provider's application to the State to become enrolled in the Medi-Cal program was submitted to the DHCS prior to January 1, 2019; and 2) Authorize Letters of Agreement (LOA) with non-Medi-Cal enrolled specialist providers identified by the Chief Medical Officer through December 31, 2019 as required for access to services or continuity of care.

Director Penrose requested that staff provide monthly updates to the Board on the progress.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized CalOptima to continue to contract with non-Medi-Cal enrolled providers through June 30, 2019, subject to CalOptima's receipt of proof that each such provider's application to the State to become enrolled in the Medi-Cal program was submitted to the DHCS prior to January 1, 2019, and authorized Letters of Agreement (LOA) with non-Medi-Cal enrolled specialist providers identified by the Chief Medical Officer through December 31, 2019 as required for access to services or continuity of care. (Motion carried 9-0-0)***

6. Consider Revisions to Policy FF.1005c: Special Payments: High Cost Exclusion Items

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors authorized modification of CalOptima Medi-Cal Policy FF.1005c, Special Payments: High Cost Exclusion Items, as follows: 1) Eliminate previous carve-out for services paid under the California Children's Services Program; 2) Implement a new procedure to require the submission of a remittance advice for qualifying services provided for PHC and HMO members; and 3) Clarify that such payments are paid to***

a contracted hospital for qualifying outpatient services, and qualifying inpatient services paid on a per diem basis. (Motion carried 9-0-0)

7. Consider Authorizing an Amendment to Amend and Extend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency

Director Sanchez did not participate in this item due to his position at the Orange County Health Care Agency and left the room during the discussion and vote. Due to potential conflicts of interest, Director Schoeffel did not participate in this item and left the room during the discussion and vote.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an amendment to the Coordination and Provision of Public Health Care Services Contract (Contract) with Orange County Health Care Agency (HCA) to extend the contract for five (5) years, through December 31, 2023, and update contract language to address programmatic and regulatory changes as summarized. (Motion carried 7-0-0; Directors Sanchez and Schoeffel absent)***

8. Consider Authorizing Extending the OneCare Physician Medical Group Shared Risk Contracts

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend and extend the Physician Medical Group (PMG) contracts with AltaMed Health Services, AMVI/Prospect Medical Group, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Monarch HealthCare, Noble Community Medical Associates and United Care Medical Group OneCare Shared Risk Physician Medical Group (PMG) contracts to: extend these agreements for the period January 1, 2019 through December 31, 2019. (Motion carried 7-0-0; Supervisor Steel recused; Director Schoeffel absent)***

9. Consider Authorizing Extending and Amending the Cal MediConnect (OneCare Connect) Health Network Contracts

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend the OneCare Connect Health Network contracts with AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan, and United Care Medical Group to: 1) Exercise CalOptima's option to extend these***

agreements through December 31, 2019, and 2) Add any necessary language provisions required based the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) and other statutory, regulatory, or contractual requirements. (Motion carried 7-0-0; Supervisor Steel recused; Director Schoeffel absent)

10. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to Provider Health Network Contracts Except Those Pertaining to the CalOptima Community Network Contracts

Chair Yost did not participate in this item due to his affiliation with CHOC as an anesthesiologist physician, and he passed the gavel to Vice Chair Khatibi and left the room during the discussion and vote. Supervisor Steel did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer to enter into contract amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, for AltaMed Health Services, AMVI Care Health Network, CHOC Physicians Network, Children's Hospital of Orange County, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Kaiser Foundation Health Plan, Monarch Health Plan, Noble Community Medical Associates, Prospect Health Plan and United Care Medical Group to continue to pay individual providers Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities for services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long the State of California continues the Prop 56 Increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance. (Motion carried 6-0-0; Supervisor Steel recused; Chair Yost and Director Schoeffel absent)***

11. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Provider Contracts Except Those Associated with St. Joseph Health and the University of California, Irvine

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network physician contracts, except those associated with St. Joseph Health and the University of California, Irvine (UCI), to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long as the State of California continues the Prop 56 Increase payments to CalOptima, which may be subject to Board approval***

and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance. (Motion carried 5-0-0; Supervisors Do and Steel recused; Chair Yost and Director Schoeffel absent)

12. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Specialist Provider Contracts Associated with St. Joseph Health

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

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network Specialist physician contracts associated with St. Joseph Health, to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance. (Motion carried 5-0-0; Supervisor Do recused; Chair Yost and Directors Penrose and Schoeffel absent)***

13. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Primary Care Provider Contracts Associated with St. Joseph Health

Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. Due to his affiliation with the St. Jude Clinic, Director DiLuigi did not participate in the discussion and vote on this item. Director Penrose did not participate in this item due to his association with St. Joseph Health and left the room during the discussion and vote. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network Primary Care Provider contracts associated with St. Joseph Health, to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19, and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance. (Motion carried 5-0-0; Supervisor Do and Director DiLuigi recused; Directors Penrose and Schoeffel absent)***

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14. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Mental Health Provider Contracts Associated with St. Joseph Health

Director DiLuigi did not participate in the discussion and vote on this item due to his affiliation with the St. Jude Clinic. Director Penrose did not participate in this item due to his association with St. Joseph Health and left the room during the discussion and vote. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network Mental Health Provider contracts associated with St. Joseph Health, to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19 and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance. (Motion carried 6-0-0; Director DiLuigi recused; Directors Penrose and Schoeffel absent)***

15. Consider Actions for the Continuation of Proposition 56 Provider Payments, Including Amendments to CalOptima Community Network Provider Contracts Associated with the University of California, Irvine

Supervisor Do did not participate in the discussion and vote on this item due to potential conflicts of interest under the Levine Act. Director Nguyen did not participate in this item and left the room during the discussion and vote due to his wife's affiliation with UCI. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend CalOptima Community Network provider contracts associated with the University of California, Irvine (UCI) to continue Proposition 56 payments for eligible services rendered in State Fiscal Year (SFY) 2018-19, and for future extensions as long as the State of California continues the Prop 56 increase payments to CalOptima, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance. (Motion carried 6-0-0; Supervisor Do recused; Directors Nguyen and Schoeffel absent)***

16. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018-19 Capital Budget for the CalOptima Provider Portal Project

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized reallocation of budgeted but unused funds of $675,000 from Capital Hardware and Software to Capital Professional Fees to fund the CalOptima Provider Portal project through June 30, 2019. (Motion carried 9-0-0)***

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17. Consider Ratifying a Revised Amendment to the Primary Agreement with the California Department of Health Care Services

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors ratified revised Amendment 33 of the Primary Agreement between CalOptima and the Department of Health Care Services. (Motion carried 9-0-0)***

18. Consider Authorizing and Directing the Chairman of the CalOptima Board of Directors to Execute an Amendment to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute Amendment A06 to the PACE agreement between the Department of Health Care Services and CalOptima to extend the agreement through December 31, 2019. (Motion carried 9-0-0)***

19. Consider Authorizing Exploration of CalOptima's Participation in Be Well Orange County
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Edwin Poon, Behavioral Health Director, and Cheryl Meronk, Strategic Development Director, presented the recommendation to authorize the Chief Executive Officer to participate in the Be Well Orange County initiative by facilitating discussions regarding one or more of the proposed result areas, and to assess the feasibility of CalOptima's participation with the Orange County Health Care Agency and various hospital systems in support of the Be Well Orange County (Be Well OC) initiative. An overview of the blueprint created by Be Well OC outlining the challenges, solutions, pillars for action, collective impact, and results areas was provided to the Board.

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer to participate in the Be Well Orange County initiative by facilitating discussions regarding one or more of the proposed result areas, and to assess the feasibility of CalOptima's participation with the Orange County Health Care Agency and various hospital systems in support of the Be Well Orange County initiative. (Motion carried 8-0-0; Director Schoeffel absent)***

20. Consider Adoption of Resolution to Amend CalOptima's Conflict of Interest Code

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors adopted Resolution No. 18-1101, adopting a Conflict of Interest Code ("Code") which supersedes all prior Conflict of Interest Codes and Amendments previously adopted; and upon adoption, directed the Clerk of the Board to submit the Code to the Orange County Board of Supervisors for review and approval. (Motion carried 9-0-0)***

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21. Consider Authorizing CalOptima to Explore Policy Opportunities to Carve-In Medi-Cal Dental Benefits for CalOptima Medi-Cal Members in Orange County

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized staff to explore policy opportunities to carve in dental benefits for CalOptima's Medi-Cal members in Orange County. (Motion carried 9-0-0)***

INFORMATION ITEMS

23. CalOptima Foundation Options

In response to Board direction at the August 2, 2018 meeting, staff presented a status report and options for the CalOptima Foundation moving forward. Proposed options included: 1) Continue with Foundation operations; 2) Spend Foundation assets and dissolve the Foundation; and 3) Return Foundation assets to CalOptima (Health Plan) and dissolve the Foundation.

Director Penrose commented on the completion of the CalOptima Regional Extension Center (COREC) initiative, and suggested that the Board consider pursuing option 3, returning Foundation assets to the Health Plan and dissolving the Foundation. After discussion of the matter, the Board directed staff to present recommendations related to option 3 to the Board for consideration at a future meeting.

The following Information Items were accepted as presented:
24. September 2018 Financial Summary
25. Compliance Report
26. Federal and State Legislative Advocates Report
27. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board members welcomed new CalOptima Chief Medical Officer David Ramirez, M.D. On behalf of the Board of Directors, Chair Yost thanked the Member and Provider Advisory Committees for their input on the proposed delivery system evaluation and CalOptima Community Network auto-assignment cap.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:58 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: December 6, 2018

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 18, 2018

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:05 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Scott Schoeffel

Members Absent: Ron DiLuigi

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

PUBLIC COMMENT
There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Greg Hamblin, Chief Financial Officer, presented an overview of the Treasurer's Report for the period April 1, 2018 through June 30, 2018. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

2. Approve the Minutes of the May 17, 2018 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the April 23, 2018 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 2-0-0; Director DiLuigi absent)***

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REPORTS

3. Consider Recommending that the Board of Directors Accept and Receive and File Fiscal Year 2018 CalOptima Audited Financial Statements

Mr. Hamblin presented the action to recommend that the Board of Directors accept and receive and file the Fiscal Year 2018 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP.

DeVon Wiens of Moss-Adams, LLP, CalOptima's independent financial auditor, presented the draft audit of the consolidated financial statement for the fiscal year ending June 30, 2018. A detailed review of the areas of audit emphasis were presented to the Committee for discussion, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. It was reported that Moss-Adams will issue an unmodified opinion on the financial statements indicating that the FY 2018 financial statements fairly state the financial condition of CalOptima in all material respects.

After discussion of the matter, the Committee took the following action.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee approved the draft Fiscal Year (FY) 2018 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP, and recommended that the Board of Directors accept and receive and file the final version of the FY 2018 consolidated audited financial statements. (Motion carried 2-0-0; Director DiLuigi absent)***

4. Consider Recommending Modification of Claims Payment Policies Associated with the Implementation of the Whole-Child Model

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize a transition period of six months for payment of certain claims for children enrolled in California Children's Services (CCS) prior to January 1, 2019 that would be denied under CalOptima Direct, CalOptima Community Network, or a Health Network to allow for adequate transition of Service Authorizations Requests (SARs) from the California Children's Services Program to CalOptima under the Whole-Child Model. (Motion carried 2-0-0; Director DiLuigi absent)***

INFORMATION ITEMS

5. Fiscal Year (FY) 2017-18 Directed Payments to Hospitals

Mr. Hamblin presented a review of the four general areas that the state has identified for FY 2017-18 directed payments to hospitals: Proposition 56, Physician Supplemental Payments; Public Hospital Enhanced Payment Program (EPP); Public Hospital Quality Incentive Pool (QIP); and Private Hospital Directed Payment (PHDP). Staff will keep the Committee informed of the progress of the directed payments to hospitals at future Finance and Audit Committee meetings.

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6. CalOptima Personal Care Coordinator Evaluation

Emily Fonda, M.D., Medical Director, presented an overview of the CalOptima Personal Care Coordinator (PCC) evaluation. The PCC role was created in 2014 to increase compliance with the Centers for Medicare & Medicaid Services (CMS) care management requirements and improve care coordination and efficiency and includes improving the care experience for members and providers, as well as increasing CalOptima oversight of health networks. All OneCare, OneCare Connect, and seniors and persons with disabilities (SPD) members are assigned a PCC who serve as the member's primary point of contact for care management. The PCC also works with contracted primary care providers, schedule and participate in Interdisciplinary Care Team (ICT) meetings as needed and facilitate the distribution of the Individual Care Plan to members of the ICT. Dr. Fonda provided a detailed review of the evaluation conducted on the impact of the PCC position, and noted that continued refinement of the PCC duties will support ongoing improvement on quality measures.

After considerable discussion of the matter, Committee members suggested that staff analyze the cost savings to determine the effectiveness of the PCC program, including the development of baseline metrics and return on investment, and engaging the health networks and the Member and Provider Advisory Committee.

7. Health Homes Program Update

Candice Gomez, Executive Director, Program Implementation, presented an update on the Health Homes Program (HHP), which was authorized under the Affordable Care Act that allowed a state plan option to create Medicaid health homes for intensive care coordination for people with chronic conditions. The California Department of Health Care Services (DHCS) selected CalOptima for implementation of the HHP in two stages: July 1, 2019 for members with chronic conditions; and January 1, 2020 for members with Serious Mental Illness or Serious Emotional Disturbance. Ms. Gomez provided an overview of the HHP eligibility criteria and program exclusions as specified by DHCS, as well as the program demographics, service requirements, health network distribution, and staffing.

Mr. Hamblin reviewed the HHP financial model including DHCS rate assumptions for this opt-in population. It was noted that California's AB 361 authorizing the implementation of the HHP requires budget neutrality and evaluation by the DHCS within two years of the initial program implementation. Committee members commented on the need to conduct an analysis of the success of this opt-in population, including measuring the return on investment.

8. July 2018 Financial Summary

Mr. Hamblin provided an overview of the balance sheet, Board-Designated Reserves and tangible net equity (TNE) requirement as of July 31, 2018.

The following Information Items were accepted as presented:

9. CalOptima Information Systems Security Update
10. Cost Containment Improvements/Initiatives
11. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

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COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work on the FY 2018 audit.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 3:59 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 15, 2018

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MINUTES

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

August 9, 2018

A Regular Meeting of the CalOptima Board of Directors' Whole Child Model Family Advisory Committee (WCM FAC) was held on August 9, 2018, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Michael Schrader, Chief Executive Officer, called the meeting to order at 3:04 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Pam Patterson, Acting Chair; Maura Byron; Sandra Cortez-Schultz; Melissa Hardaway; Diane Key; Grace Leroy-Loge; Kristen Rogers

Members Absent: Malissa Watson

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Candice Gomez, Executive Director, Program Implementation; Emily Fonda, MD, Medical Director; Tracy Hitzeman, Executive Director, Clinical Operations; Sesha Mudunuri, Executive Director, Operations; Belinda Abeyta, Director, Customer Service; Le Nguyen, Associate Director, Customer Service; Cheryl Simmons, Project Manager; Eva Garcia, Program Assistant, Customer Service

PUBLIC COMMENT

There were no requests for Public Comment.

REPORTS

Consider Appointment of FY2018-2019 Whole Child Model Family Advisory Committee (WCM FAC) MAC Chair

Michael Schrader, Chief Executive Officer, informed WCM FAC members of the need for the committee to recommend a nominee to the CalOptima Board of Directors to serve as WCM FAC Chair and Vice Chair for the remainder of the fiscal year. To allow WCM FAC members time to consider whether they would like to nominate one of their fellow committee members or be considered for this role, the item will be agendized for consideration at the next WCM FAC meeting. For purposes of this meeting, WCM FAC member Pam Patterson volunteered to serve as Acting Chair for the balance of the meeting.

Action: ***On motion of Committee Member Byron, seconded and carried, the WCM FAC approved the Acting Chair. (Motion carried 7-0; Member Watson absent)***

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Consider Approval of FY2018-19 Whole-Child Model Family Advisory Committee Meeting Schedule

Acting Chair Patterson, presented the proposed FY2018-19 Whole-Child Model Family Advisory Committee Meeting Schedule. As proposed, the Committee will meet on the second Thursday in the months of August, October, December, February, April, and June at 3 p.m. Unless otherwise notified, all meetings will be held at CalOptima.

Action: ***On motion of Committee Member Byron, seconded and carried, the WCM FAC approved the FY 2018-2019 meeting schedule as presented. (Motion carried 7-0; Member Watson absent)***

CEO MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Office, reported on the transition of California Children's Services (CCS) to Medi-Cal Managed Care via the Whole Child Model (WCM). The Department of Health Care Services DHCS) is implementing the WCM with five Health Plans. Three of the five Health Plans implemented WCM effective July 1, 2018, and two Health Plans, including CalOptima, will implement WCM effective January 1, 2019. Mr. Schrader also reported that CalOptima is actively recruiting for three additional Family Representatives for the WCM FAC committee.

INFORMATION ITEMS

Whole-Child Model Family Advisory Committee (WCM FAC) Governance

Gary Crockett, Chief Counsel, provided an overview of public agency requirements and WCM FAC member responsibilities, and explained that CalOptima and its Board, Board Standing Committees, and advisory committees are subject to laws and regulations governing local public agencies.

Whole Child Model (WCM) Program Overview

Candice Gomez, Executive Director, Program Implementation, provided an overview of the WCM program. In addition, Ms. Gomez provided information on CalOptima's general stakeholder meetings, community-based organizations focus groups, employee focus groups, and family events.

ADJOURNMENT

Acting Chair Patterson announced that the next WCM FAC meeting is Thursday, October 18, 2018 at 2:30 p.m.

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Hearing no further business, Acting Chair Patterson adjourned the meeting at 4:14 p.m.

/s/ Eva Cortez
Eva Cortez
Administrative Assistant

Approved: November 8, 2018

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
3. Consider Approval of Proposed Changes to CalOptima Policy GA.3400: Annual Investments

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

Recommended Action
Approve proposed changes to CalOptima Policy GA.3400: Annual Investments.

Background
At the February 27, 1996 meeting, the CalOptima Board of Directors (Board) approved the original AIP covering investments made between March 1, 1996 and February 28, 1997. In September 1996, the Board authorized the creation of the Investment Advisory Committee (IAC). The IAC reviews the AIP each year, and recommends changes in said policy to the FAC and the Board for their respective approvals.

At the December 7, 2017 meeting, the Board approved changes to the AIP for CY 2018. At that time, staff, in conjunction with Meketa Investment Group, Inc., and CalOptima's investment managers, Payden & Rygel, Logan Circle Partners and Wells Capital Management, recommended revisions to the AIP to:

- Delete Temporary Liquidity Guarantee (TLG) Program securities and Temporary Corporate Credit Union Liquidity Guarantee Program (TCCULGP) securities from the list of permitted investments with U.S. Government related organizations, as both programs expired.
- Add language that prohibits private placement (144a) securities as a permitted investment.
- Revise the maximum holding percentages for State and California Local Agency Obligations from 25% to 30% and Supranational Obligations from 15% to 30%.

Discussion
Payden & Rygel, Logan Circle Partners, and Wells Capital Management, CalOptima's investment managers, and Meketa Investment Group, Inc., CalOptima's investment adviser submitted proposed revisions to the AIP for CY 2019. Staff has reviewed the proposed revisions and recommends the following changes upon Board approval:

- Section III.D.1.a: Increase the maximum term of Operating Fund from four hundred fifty (450) days to two (2) years, unless otherwise specified in the policy. The increase to the term falls within the 5-year term allowed by California Government Code section 53600 et seq. This would provide investment managers a wider opportunity set in their Operating Fund portfolio.
    - Section III.D.2.a.iv: US Treasuries, term assigned changed from 450 days to 2 years.
    - Section III.D.2.b.iii: Federal Agencies and U.S. Government Sponsored Enterprises, term assigned changed from 450 days to 2 years.

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  - Section III.D.2.c.ii: State and California Local Agency Obligations, term assigned changed from 450 days to 2 years.
  - Section III.D.2.h.ii: Corporate Securities, term assigned changed from 450 days to 2 years.
  - Section III.D.2.k.iv: Mortgage or Asset-backed Securities, term assigned changed from 450 days to 2 years.
  - Section III.D.2.l.iii: Variables and Floating Rate Securities, term assigned changed from 450 days to 2 years.
  - Section III.D.2.m.iii: Supranational Obligations, term assigned changed from 450 days to 2 years.

- Section III.D.2.h.i: Corporate Securities, modify language from "rated 'A' or better" to "A" rating category. This is to clarify the existing policy language to include "A-" securities in the allowed portfolio.

- Sections III.D.2.l.ii: Variable and Floating Rate Securities, add the Secured Overnight Financing Rate (SOFR) to the allowed index list. This change does not materially alter the policy or allow for a new type of investment. Following the same guidance, SOFR will be used as an index rate for variance and floating rate securities.

- Glossary Term: State and California Local Agency Obligations, revised existing language to allow the purchase of registered warrants, notes or bonds issued by a state or by a department, board, agency, or authority of any of the fifty U.S. states, and California local agencies , which is consistent with California Code, section 53601. This change updates the existing glossary term to be consistent with California Code.

In addition to the proposed changes noted above, the attached red-lined version of the AIP for CY 2019 reflects some non-substantive formatting revisions.

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
The proposed changes to the AIP for CY 2019 reflect the recommendations of CalOptima's investment managers, Payden & Rygel, Logan Circle Partners, and Wells Capital Management and concurrence by CalOptima's investment adviser, Meketa Investment Group, Inc. These recommended changes continue to support CalOptima's goals to maintain safety of principal, and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for the CY 2019.

Concurrence
Meketa Investment Group, Inc.
Gary Crockett, Chief Counsel
Board of Directors' Investment Advisory Committee
Board of Directors' Finance and Audit Committee

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Attachments
Policy GA.3400: Annual Investments – redline and clean versions.

/s/ Michael Schrader *11/28/2018*
Authorized Signature **Date**

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Policy #: GA.3400
Title: **Annual Investments**
Department: Finance
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/18
Last Review Date: TBD~~Not Applicable~~
Last Revised Date: TBD~~Not Applicable~~

~~*Board Approved Policy*~~

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima invested on or after January 10, 2006 to ensure CalOptima's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve capital, provide necessary liquidity, and achieve a market-average rate of return through economic cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima and, as such, each investment transaction shall seek to ensure that large capital losses are avoided from securities or broker-dealer default.

   a. CalOptima shall seek to ensure that capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the investment portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching maturity dates, to the extent possible, with CalOptima's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima. It is important that each portfolio contain investments for which there is a secondary market and which offer the flexibility to be easily sold at any time with minimal risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima's investment portfolios shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk, established by the Board of Directors' and the CalOptima Treasurer's objectives.

    a. The performance benchmark for each investment portfolio shall be based upon published market indices for short-term investments of comparable risk and duration.

        i. These performance benchmarks shall be reviewed monthly by CalOptima's Treasurer and the Investment Managers and shall be approved by the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the custodian bank acting as the agent of CalOptima under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from broker-dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions.

1. CalOptima's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima's investments.

F. On an annual basis, CalOptima's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made are following this Policy.

1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

1. Authority to manage CalOptima's investment program is derived from an order of the Board of Directors.

a. Management responsibility for the investment program shall be delegated to CalOptima's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima's Treasurer.

B. CalOptima Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima's investment portfolio;

c. Directing CalOptima's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima.

2. The Investment Advisory Committee shall be responsible for the following functions:

a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of CalOptima's investment portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to CalOptima's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to CalOptima's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima shall invest only in instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of ~~four hundred fifty (450) days.~~ two (2) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. Private placement (144a) securities are prohibited.

d. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or bonds, that offer protection from inflation. Coupon payments and underlying principal are automatically increased to compensate for inflation, as measured by the consumer price index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	~~450 days~~2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	~~450 days~~2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or equivalent or better for short-term obligations, or A by Moody's, or A by Standard & Poor's, or better, for long-term debt. Public agency bonds issued for private purposes (e.g., industrial development bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	~~450 days~~2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the

bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and

b) May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) Rated P-1 by Moody's, or A-1, or better, by Standard & Poor's;

b) Have an A, or higher, rating for the issuer's debt, other than CP, if any, as provided for by Moody's, or Standard & Poor's;

c) Issued by corporations organized and operating within the United States and having total assets in excess of five hundred million dollars ($500,000,000) or by corporations organized within the U.S. as special purpose corporations, trusts, or LLCs, which have program-wide credit enhancements, including but not limited to, overcollateralization, letter of credit, or a surety bond, and have commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized statistical rating agency; and

d) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	1 year	5 years
▪ Tier Two (2)	1 year	5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary broker-dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, provided:

a) A broker-dealer master repurchase agreement signed by the Investment Manager (acting as "Agent") and approved by CalOptima;

b) The securities are held free and clear of any lien by CalOptima's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined capital, surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any lien, as agent for CalOptima's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima's custodian and CalOptima; and

d) The Agent will notify CalOptima's custodian and CalOptima if the valuation of the collateral securities falls outside of policy. Upon direction by the CalOptima Treasurer, the Agent will liquidate the collateral securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse repurchase agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible corporate securities shall ~~be rated~~ have an "A" rating category or better by Moody's, Standard & Poor's, or Fitch Ratings Service and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to commercial paper, i.e., medium term notes (MTNs).

c) Under no circumstance can the MTNs or any other corporate security of any one (1) corporate issuer represent more than five percent (5%) of the portfolio.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	~~450 days~~2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code, Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint

powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A joint powers authority pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the joint powers authority pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA- by a nationally recognized rating service; and

b) Are issued by an issuer having an "A" (Code), or better, rating by a nationally recognized rating service for its long-term debt.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	~~450 days~~2 years	5 years

Board-Designated Reserve Funds ▪ Tier One (1)	5 years stated final maturity	5 years
▪ Tier Two (2)	5 years stated final maturity	5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce risk.

a) They should have the same stability, liquidity, and quality as traditional money market securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years from the date of purchase.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	~~450 days~~2 years	5 years
Board-Designated Reserve Funds		

▪ Tier One (1) ▪ Tier Two (2)	5 years 5 years	5 years 5 years

m. Supranational Obligations

i. The three (3) supranational institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated AA by two (2) of the three (3) largest nationally recognized rating services.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	~~450 days~~2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio liquidity should one (1) sector or company experience difficulties.

2. CalOptima's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	30% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code)
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

    i. Any one Federal Agency or Government Sponsored Enterprise: None

    ii. Any one repurchase agreement counterparty name:

    If maturity/term is ≤ 7 days: 50%
    If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

    i. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum applies to all such securities backed by the same type of assets of the same issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

    i. If one (1) Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima's Treasurer and Investment Advisor (if any) by close of business on the day of the occurrence.

    ii. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in:

        a) The context of the amount in relation to the total portfolio concentration;

        b) Market and security specific conditions contributing to a breach of this Policy; and

c) The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security.

G. Rating Downgrades

1. CalOptima may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by CalOptima's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or broker-dealer.

2. The investment portfolio or investment portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide its Investment Managers and Investment Advisor with a list, should such a list be adopted by CalOptima in the future, of organizations that do not comply with this Policy and shall immediately notify its Investment Managers and Investment Advisor of any changes.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

~~A. California Government Code, §6509.7~~
~~B.~~A. California Government Code, §53600 et seq.
B. California Government Code, §53601.5
C. California Government Code, §53608
~~C.~~D. California Government Code, §53635 et seq.
~~D.~~E. California Government Code. §53646, Subdivision (a) and Subdivision (b)
F. California Government Code, §6509.7
~~E.~~G. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVALS

A. None to Date

VII. BOARD ACTIONS

A. 11/05/18: Special Meeting of the CalOptima Investment Advisory Committee
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 11/16/17: Regular Meeting of the CalOptima Finance Advisory Committee
~~C. 12/03/15: Regular Meeting of the CalOptima Board of Directors~~
~~D. 03/05/15: Regular Meeting of the CalOptima Board of Directors~~
~~E. 06/05/14: Regular Meeting of the CalOptima Board of Directors~~
~~F. 12/05/13: Regular Meeting of the CalOptima Board of Directors~~
~~G. 01/03/13: Regular Meeting of the CalOptima Board of Directors~~
~~H. 10/04/12: Regular Meeting of the CalOptima Board of Directors~~
~~I. 01/06/11: Regular Meeting of the CalOptima Board of Directors~~
~~J. 08/05/10: Regular Meeting of the CalOptima Board of Directors~~
~~K. 12/04/08: Regular Meeting of the CalOptima Board of Directors~~
~~L. 12/07/04: Regular Meeting of the CalOptima Board of Directors~~
~~M. 01/07/03: Regular Meeting of the CalOptima Board of Directors~~
~~N. 01/11/00: Regular Meeting of the CalOptima Board of Directors~~
~~O. 03/03/98: Regular Meeting of the CalOptima Board of Directors~~
~~P. 02/04/97: Regular Meeting of the CalOptima Board of Directors~~
~~Q. 02/27/96: Regular Meeting of the CalOptima Board of Directors~~

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	TBD	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, risk and return of a portfolio.

Term	Definition
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima's regulatory compliance requirements; or b. Currently defined as CalOptima's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a broker-dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.

Term	Definition
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial instrument or asset that can be traded. These assets can be cash, bonds, or shares in a company
Investment Advisors	Members of CalOptima Investment Advisory Committee (IAC).
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding the organization's investments.
Investment Managers	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the underlying pool of securities owned by the joint powers authority.

Term	Definition
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.

Term	Definition
State and California Local Agency Obligations	Registered ~~state~~ warrants, ~~treasury~~ notes or bonds of any of the fifty (50) U.S. ~~state and~~states, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, bonds, notes, warrants, or other evidences of indebtedness of any local agency ~~of~~within the State of California, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the valuation of each financial instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual valuations.

Policy #: GA.3400
Title: **Annual Investments**
Department: Finance
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/18
Last Review Date: TBD
Last Revised Date: TBD

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima invested on or after January 10, 2006 to ensure CalOptima's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve capital, provide necessary liquidity, and achieve a market-average rate of return through economic cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima and, as such, each investment transaction shall seek to ensure that large capital losses are avoided from securities or broker-dealer default.

   a. CalOptima shall seek to ensure that capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the investment portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching maturity dates, to the extent possible, with CalOptima's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima. It is important that each portfolio contain investments for which there is a secondary market and which offer the flexibility to be easily sold at any time with minimal risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima's investment portfolios shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk, established by the Board of Directors' and the CalOptima Treasurer's objectives.

    a. The performance benchmark for each investment portfolio shall be based upon published market indices for short-term investments of comparable risk and duration.

        i. These performance benchmarks shall be reviewed monthly by CalOptima's Treasurer and the Investment Managers and shall be approved by the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the custodian bank acting as the agent of CalOptima under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from broker-dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions.

1. CalOptima's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima's investments.

F. On an annual basis, CalOptima's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made are following this Policy.

1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

1. Authority to manage CalOptima's investment program is derived from an order of the Board of Directors.

    a. Management responsibility for the investment program shall be delegated to CalOptima's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima's Treasurer.

B. CalOptima Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima's investment portfolio;

c. Directing CalOptima's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima.

2. The Investment Advisory Committee shall be responsible for the following functions:

a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of CalOptima's investment portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to CalOptima's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to CalOptima's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima shall invest only in instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of two (2) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. Private placement (144a) securities are prohibited.

d. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or bonds, that offer protection from inflation. Coupon payments and underlying principal are automatically increased to compensate for inflation, as measured by the consumer price index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years	5 years
▪ Tier Two (2)	5 years	5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or equivalent or better for short-term obligations, or A by Moody's, or A by Standard & Poor's, or better, for long-term debt. Public agency bonds issued for private purposes (e.g., industrial development bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and

b) May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days
Board-Designated Reserve Funds		
▪ Tier One (1)	180 days	180 days
▪ Tier Two (2)	180 days	180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) Rated P-1 by Moody's, or A-1, or better, by Standard & Poor's;

b) Have an A, or higher, rating for the issuer's debt, other than CP, if any, as provided for by Moody's, or Standard & Poor's;

c) Issued by corporations organized and operating within the United States and having total assets in excess of five hundred million dollars ($500,000,000) or by corporations organized within the U.S. as special purpose corporations, trusts, or LLCs, which have program-wide credit enhancements, including but not limited to, overcollateralization, letter of credit, or a surety bond, and have commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized statistical rating agency; and

d) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds		
▪ Tier One (1)	270 days	270 days
▪ Tier Two (2)	270 days	270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary broker-dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, provided:

a) A broker-dealer master repurchase agreement signed by the Investment Manager (acting as "Agent") and approved by CalOptima;

b) The securities are held free and clear of any lien by CalOptima's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined capital, surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any lien, as agent for CalOptima's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima's custodian and CalOptima; and

d) The Agent will notify CalOptima's custodian and CalOptima if the valuation of the collateral securities falls outside of policy. Upon direction by the CalOptima Treasurer, the Agent will liquidate the collateral securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse repurchase agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible corporate securities shall have an "A" rating category or better by Moody's, Standard & Poor's, or Fitch Ratings Service and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to commercial paper, i.e., medium term notes (MTNs).

c) Under no circumstance can the MTNs or any other corporate security of any one (1) corporate issuer represent more than five percent (5%) of the portfolio.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years	5 years
▪ Tier Two (2)	5 years	5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code, Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A joint powers authority pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the joint powers authority pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds		
▪ Tier One (1)	Not Applicable	Not Applicable
▪ Tier Two (2)	Not Applicable	Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA- by a nationally recognized rating service; and

b) Are issued by an issuer having an "A" (Code), or better, rating by a nationally recognized rating service for its long-term debt.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years stated final maturity	5 years
▪ Tier Two (2)	5 years stated final maturity	5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce risk.

a) They should have the same stability, liquidity, and quality as traditional money market securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years from the date of purchase.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years	5 years
▪ Tier Two (2)	5 years	5 years

m. Supranational Obligations

i. The three (3) supranational institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated AA by two (2) of the three (3) largest nationally recognized rating services.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	2 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio liquidity should one (1) sector or company experience difficulties.

2. CalOptima's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	30% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code)
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

i. Any one Federal Agency or Government Sponsored Enterprise: None

ii. Any one repurchase agreement counterparty name:

If maturity/term is ≤ 7 days: 50%
If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

i. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum applies to all such securities backed by the same type of assets of the same issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

i. If one (1) Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima's Treasurer and Investment Advisor (if any) by close of business on the day of the occurrence.

ii. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in:

a) The context of the amount in relation to the total portfolio concentration;

b) Market and security specific conditions contributing to a breach of this Policy; and

c) The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security.

G. Rating Downgrades

1. CalOptima may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by CalOptima's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or broker-dealer.

2. The investment portfolio or investment portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide its Investment Managers and Investment Advisor with a list, should such a list be adopted by CalOptima in the future, of organizations that do not comply with this Policy and shall immediately notify its Investment Managers and Investment Advisor of any changes.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Government Code, §53600 et seq.
B. California Government Code, §53601.5
C. California Government Code, §53608
D. California Government Code, §53635 et seq.
E. California Government Code. §53646, Subdivision (a) and Subdivision (b)
F. California Government Code, §6509.7
G. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVALS

A. None to Date

VII. BOARD ACTIONS

A. 11/05/18: Special Meeting of the CalOptima Investment Advisory Committee
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 11/16/17: Regular Meeting of the CalOptima Finance Advisory Committee

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	TBD	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, risk and return of a portfolio.

Term	Definition
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima's regulatory compliance requirements; or b. Currently defined as CalOptima's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a broker-dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Treasurer	Appointed by CalOptima's Board of Directors, the treasurer is a person responsible for overseeing CalOptima's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.

Term	Definition
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Board of Directors with oversight responsibilities for all financial matters of CalOptima including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial instrument or asset that can be traded. These assets can be cash, bonds, or shares in a company
Investment Advisors	Members of CalOptima Investment Advisory Committee (IAC).
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding the organization's investments.
Investment Managers	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the underlying pool of securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).

Term	Definition
Market Risk	The risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or bonds of any of the fifty (50) U.S. states, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.

Term	Definition
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial instrument or asset. CalOptima's asset managers provide CalOptima with reporting that shows the valuation of each financial instrument that they own on behalf of CalOptima. Each asset manager uses a variety of market sources to determine individual valuations.

1

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Action
Consider reappointment of David Young for a two-year term on the CalOptima Board of Directors' Investment Advisory Committee ending October 7, 2020.

Background
At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee. IAC members do not make recommendations on individual investments. However, their role is to make recommendations to the Finance and Audit Committee (FAC) on changes to the Annual Investment Policy (AIP), and to monitor the performance of CalOptima's investments, investment advisor and investment managers.

When creating the IAC, the Board stipulated that the Committee would consist of five (5) members, one (1) member would automatically serve by virtue of his or her position as CalOptima's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possessing experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities. The IAC currently has six members due to a recent committee member resignation triggered by a job relocation out of Orange County.

Discussion
The following candidate recommended for reappointment has consistently provided leadership and service to CalOptima's investment strategies through his participation as a member of the IAC.

David Young has served as a member of the IAC since June 4, 2009. Mr. Young is founder and Chief Executive Officer of Anfield Group, LLC, a financial consulting and investment advisory firm. In 2008, he retired as Executive Vice President and Account Manager of Pacific Investment Management Company (PIMCO) and rejoined the University of California, Irvine (UCI), Paul Merage School of Business as Adjunct Professor. From 1999 to 2006, he was head of PIMCO's account management group in London. Prior to that, Mr. Young held positions at Analytic Investment Management, Smith Barney, and Harris Upham. He has over 30 years of investment experience and is a Certified Financial

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Advisor (CFA). In addition, Mr. Young is a member of the CFA Society of Orange County Board of Directors, and the chair of its Investment Committee. He also is board member of the UCI Paul Merage School of Business Center for Investment & Wealth Management Executive Committee and chairs its Journal editorial board. Mr. Young received his undergraduate degree and M.B.A from UCI.

Mr. Young was previously appointed to the IAC by the CalOptima Board of Directors on October 6, 2016 for a term ending October 6, 2018. Appointment for an additional term is now recommended.

Fiscal Impact
There is no fiscal impact. An individual appointed to the IAC would assist and advise CalOptima in safely maintaining an acceptable return on investment of available funds.

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

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Investment Advisory Committee
Board of Directors' Finance and Audit Committee

Attachments
None

/s/ Michael Schrader — *11/28/2018*
Authorized Signature — **Date**

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Continued to February 7, 2019 Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

5. Consider Authorizing Contracts with Out-of-Area Hospitals for the Provision of Services to CalOptima Care Network, CalOptima Direct and Shared Risk Group Members to Facilitate the Payment of Department of Health Care Services Hospital Directed Payments

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Enter into contracts at the equivalent of Medi-Cal Rates with out-of-area hospitals providing Medi-Cal covered services to CalOptima Care Network, CalOptima Direct and Share Risk Group members.
2. Authorize staff to make these contracts effective:
    a. July 1, 2017 for purposes of the Department of Health Care Services' (DHCS) hospital Directed Payment program only;
    b. On a prospective basis for all other purposes, with these hospitals not eligible to receive more in payment for services (not including any Directed Payments) than they would otherwise have been eligible to receive at the time the services were provided (i.e., payments made at non-contract rates).

Background/Discussion

CalOptima's members may on occasion, have the need to access hospital services outside the service area especially when members are treated for an emergency, which may result in an inpatient admission. As a result, certain hospitals rendering these covered services have requested contracts with CalOptima. In the past, CalOptima has not contracted with out-of-area hospitals unless they meet certain access criteria (e.g., transplant, tertiary care, etc.)

Prior to FY 2017-18, the State of California, managed a program which provided supplemental payments to hospitals serving Medi-Cal beneficiaries. The program, known as the Hospital Quality Assurance Fee, provided for payments to hospitals based on regulatory-defined criteria. The payment amount per hospital was determined by the State, with the funds sent to Managed Care Plans who passed through these payments to hospitals based on State direction.

The Centers for Medicare & Medicaid Services (CMS) instituted the Final Rule which was intended to modernize Medicaid managed care regulations. The Final Rule disallowed the California hospital pass-through payment methodology as s as currently defined. The current program payments are capped at levels in effect in 2016 and are to be phased out in 10 years.

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In light of new CMS requirements, the Department of Health Care Services (DHCS) has implemented a new hospital Directed Payment Program effective for fiscal years 2017-18 and 2018-19. This program facilitates enhanced reimbursement to eligible and participating network hospitals for contract services.

Enhanced payments are allowed for hospitals, providing services to Medi-Cal beneficiaries actively enrolled in a Medi-Cal Plan. The contracts must meet defined criteria listed below.

1. The agreement must cover one or more defined non-excluded populations of Medi-Cal beneficiaries and must not be limited to a single patient only.
2. The agreement must cover a defined set of one or more non-excluded hospital services, or when applicable non-hospital services, and must not be limited to treatment of a single case or instance only.
3. The agreement must specify rates of payment or include a defined methodology for calculating specific rates of payment for services performed, applicable to the services and populations covered by the agreement and must not permit payment to be negotiated on a per patient or single instance of service basis.
4. The agreement must not expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement.
5. The agreement must be for a set duration of at least 120 days.

As noted above, facilities must be contracted with Managed Care Plans (MCP) in order to take advantage of Directed Payments, and the program start date is retro-active back to July 1, 2017. DHCS guidance allows MCPs and facilities to establish a retroactive effective date for purposes of this program, and Staff is recommending that the contract effective dates for this purpose be set retroactive to July 1, 2017, to the extent permitted by applicable law.

Although CalOptima will not seek contracts with out-of-area hospitals for the purpose of receiving directed payments, hospitals interested in contracting may contact CalOptima. As part of the contracting process, out-of-area hospitals must pass CalOptima credentialing and maintain credentialing standards throughout the contract term. As proposed, the out-of-area hospitals will not be considered in-network for purposes of directory listing or payment of in-network participating hospital rates and programs.

In line with the DHCS retroactive effective date, staff recommends establishing a fee-for-service contract for purposes of the DHCS's Directed Payment program at the equivalent of Medi-Cal Rates, effective July 1, 2017 for purposes of directed payment.

Fiscal Impact

The recommended actions to enter into contracts with out-of-area hospitals providing Medi-Cal covered services to CalOptima Care Network, CalOptima Direct and Share Risk Group members; and to authorize staff to establish a retroactive contract effective date of July 1, 2017, is projected to be budget

Continued to February 7, 2019 Board Meeting

neutral. CalOptima plans to pass through directed payments to participating hospitals, with no fiscal impact to CalOptima. Additionally, since contracted rates will be set equivalent to Medi-Cal rates, CalOptima will not be subject to additional payments for hospital services performed at the newly-contracted facilities.

Rationale for Recommendation

The approval of this action will allow out-of-area hospitals providing limited services to CalOptima members to take advantage of Directed Payments which supplement the payments hospitals receive for providing services to CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Memorandum to all Medi-Cal Managed Care Plans and Hospitals, dated October 5, 2018
2. SFY 2017/18 Public Enhanced Payment Program (EPP) and Private Hospital Directed Payment Program (PHDP) – DHCS Toolkit and Technical Assistance Webinar
3. DHCS Hospital Directed Payment & Enhanced Payment Program, Policy & Data Logic – Plan Webinar, dated October 31, 2018

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

11/28/2018 — **Date**

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Department of Health Care Services

MEMORANDUM

DATE: 10/05/2018

TO: All Medi-Cal Managed Care Health Plans and Hospitals

FROM: Lindy Harrington
Deputy Director, Health Care Financing

SUBJECT: Hospital Directed Payment Definition for SFY 2017-18 and SFY 2018-19

The SFY 2017-18 and SFY 2018-19 hospital directed payment programs implement enhanced reimbursement to eligible and participating network hospitals for contract services. The below describes the requirements for a service provided by a hospital to qualify as a contract service by a network provider such that it is eligible for receipt of the following directed payments approved by CMS under 42 C.F.R. §438.6(c) when providing eligible contract services to Medi-Cal enrollees:

- Designated Public Hospital Enhanced Payment Program (as detailed at this link),
- Designated Public Hospital Quality Incentive Program (as detailed at this link), and
- Private Hospital Directed Payment Program (as detailed at this link).

For purposes of these specific hospital directed payments, a contract service performed by a network hospital is a Medi-Cal covered service rendered to a beneficiary actively enrolled in a Medi-Cal managed care health plan (MCP) by an eligible hospital pursuant to a contractual arrangement that meets the minimum criteria outlined in this notice for the applicable date(s) of service. The minimum criteria necessary to qualify for the directed payment for the non-excluded population types and non-excluded service providers are:

1. The agreement must cover one or more defined non-excluded populations of Medi-Cal beneficiaries and must not be limited to a single patient only.
2. The agreement must cover a defined set of one or more non-excluded hospital services, or when applicable non-hospital services, and must not be limited to treatment of a single case or instance only.
3. The agreement must specify rates of payment, or include a defined methodology for calculating specific rates of payment for services performed, applicable to the services and populations covered by the agreement, and must not permit payment to be negotiated on a per patient or single instance of service basis.
4. The agreement must not expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement.
5. The agreement must be for a set duration of at least 120 days.

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In delegated arrangements where there is not a direct contract between the MCP and the hospital rendering services, there must be a demonstrable unbroken contracting path between the MCP and the provider for the service rendered, the member receiving the service, and the applicable dates of service that meets minimum criteria listed above. In this context, “unbroken contracting path” means a sequence of contracts meeting the minimum criteria defined above, linking the MCP and a direct subcontractor, or series of subcontractors, to the provider.

Commencing with rating periods beginning on or after July 1, 2019 (SFY 2019-20), in order for a hospital to qualify as a network provider of contracted services for receipt of the above-specified directed payments, the hospital and MCP must demonstrate to DHCS, in a form and manner required by DHCS, that all contractual arrangements linking the network hospital to the MCP comply with all applicable State and Federal requirements related to network providers and subcontractors in addition to the standards set forth in this guidance.

SFY 2017-18 Enhanced Payment Program
Volume Chart Review Toolkit
Version: October 19, 2018

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Summary

The Department of Health Care Services (DHCS) is implementing the state fiscal year (SFY) 2017-18 Designated Public Hospital (DPH) Enhanced Payment Program (EPP), applicable to qualifying services during the service period of July 1, 2017 through June 30, 2018. The EPP was approved in concept by the federal Centers for Medicare & Medicaid Services (CMS) on April 2, 2018, and provides supplemental reimbursement to participating DPHs based on the actual utilization of qualifying services, as reflected in Medi-Cal managed care encounter data reported to DHCS.

To assist the ongoing EPP implementation efforts, DHCS will periodically provide encounter volume charts to participating DPHs and Medi-Cal managed care plans (Plans) for Medi-Cal managed care utilization associated with the National Provider Identifiers (NPIs) reported by

participating DPHs. The volume charts are intended to facilitate discussions between DPHs and Plans to ensure the accuracy and completeness of the encounter data.

Purpose

The purpose of this document is to provide the information needed to interpret and evaluate the encounter volume charts, such as data definitions and logic, as well as guidance related to reviewing encounter data and information about the EPP policy overall. This toolkit will be posted on DHCS's public website: http://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx The toolkit will be periodically updated as necessary, and updates will be recorded in a change log (see Appendix E).

Additional resources, including a statewide directory of DPH and Plan contacts, will also be posted on DHCS's public website at the same location and periodically updated.

Volume Charts

DHCS will save your organization's encounter volume chart(s) on a Secure File Transfer Protocol (SFTP) site accessible through this link: https://etransfer.dhcs.ca.gov/.

Follow the steps below to retrieve your organization's encounter volume chart(s):

1. Have your organization's designated SFTP Contact(s) log in to the SFTP site using their assigned user login and selected password.

2. If accessing the SFTP site for the first time using the temporary password provided by DHCS, immediately change the temporary password to a unique password.

3. In the upper left corner of the front page, click "Folders".

4. Click to open the "DHCS-CRDD-HospitalFinancing" folder.

5. Click to open either the "Public Hospitals" folder (for DPHs only) or the "Health Plans" folder (for Plans only).

6. Click to open the folder(s) corresponding to your organization.

7. Transfer the two files to your organization's servers. The files are:
    a. An encounter volume chart (summary counts) in a pivot table format, and
    b. A raw data file (encounter-level detail including Protected Health Information) in tab delimited format (see Appendix B).
        i. This file includes all Medi-Cal managed care utilization for the applicable service period associated with your organization based on the NPIs reported by DPHs, including utilization associated with excluded services (see EPP: Structure and Policy).

DHCS anticipates providing encounter volume charts on multiple occasions; the current encounter volume chart release schedule is outlined in Appendix A. For a sample of an encounter volume chart, please see Appendix F.

The data releases will consist of four files: a detail (.tab) file and a summary (.xlsx) file for Phase I (July 1, 2017 through December 31, 2017) and a detail and a summary file for the portion of Phase II we are presently releasing (January 1, 2018 through February 28, 2018).

Review Steps for Hospitals

If you identify material differences between the service counts reflected on your encounter volume chart(s) and your anticipated service counts, follow these steps:

1. Are the differences related to Plans (see Appendix D) with which you were contracted (either directly or indirectly through a delegated arrangement) to provide qualifying services during the applicable service period?
    a. If no, do not proceed, as these services are not eligible for EPP payments.
    b. If yes, proceed to step 2.

2. Are you comparing utilization for the same service period covered by the encounter volume chart(s)?
    a. If no, align to the service period covered by the encounter volume chart(s).
    b. If yes, proceed to step 3.

3. Is your service logic aligned with the encounter volume chart logic (see Appendix C)?
    a. If no, align to DHCS' encounter volume chart logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.

4. Are you applying the appropriate exclusions (see EPP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS's counting logic.
    b. If yes, proceed to step 5.

5. Are the differences related to NPIs that are missing from the encounter volume chart(s)?
    a. If no, proceed to step 6.
    b. If yes, verify the NPI is not related to an excluded provider type (i.e. CBRC, FQHC, IHCP, or RHC).
        i. If there is still a variance, notify DHCS at PublicDP@dhcs.ca.gov in order to report the missing NPI(s) and troubleshoot the issue.
        ii. Once you have notified DHCS, proceed to step 6 for NPIs that are included in the encounter volume chart(s).

6. Are your anticipated service counts still materially different from the service counts reflected on your encounter volume chart(s)?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.

7. Work with your affected Plan partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected Plan partner(s) able to identify and resolve the data deficiencies?
    a. If no, proceed to step 8
    b. If yes, no further action is needed.

    Note: Discrepancies may be due to multiple factors such as: (i) the Plan did not receive encounters (or required data was missing); (ii) the Plan did not submit encounters to DHCS; and (iii) encounters were rejected by DHCS's system edits.

8. Contact DHCS at PublicDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Review Steps for Plans

If you identify material differences between the service counts reflected on your encounter volume chart and your anticipated service counts, follow these steps:

1. Are the differences related to DPHs with which you were contracted (either directly or indirectly through a delegated arrangement) for qualifying services during the applicable service period?
    a. If no, do not proceed, as these services are not eligible for EPP payments.
    b. If yes, proceed to step 2.

2. Are you comparing utilization for the same service period covered by the encounter volume chart?
    a. If no, align to the service period covered by the encounter volume chart.
    b. If yes, proceed to step 3.

3. Is your service logic aligned with DHCS's encounter volume chart logic (see Appendix C)?
    a. If no, align to DHCS' encounter volume chart logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.

    Note: The encounter volume chart logic is not the same as the RDT logic.

4. Are you applying the appropriate exclusions (see EPP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS's counting logic.
    b. If yes, proceed to step 5.

5. Are the differences related to NPIs that are missing from the encounter volume chart?
    a. If no, proceed to step 6.
    b. If yes, notify the DPH that the NPI is not included in the encounter volume chart, and then proceed to step 6 for NPIs that are included.

6. Are your anticipated service counts still materially different from the service counts reflected on your encounter volume chart?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.

7. Work with your DPH partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected DPH partner(s) able to identify and resolve the data deficiencies?
    c. If no, proceed to step 8
    d. If yes, no further action is needed.

    Note: Discrepancies may be due to multiple factors such as: (i) the Plan did not receive encounters (or required data was missing); (ii) the Plan did not submit encounters to DHCS; and (iii) encounters were rejected by DHCS's system edits.

8. Contact DHCS at PlanDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Background

Prior to SFY 2017-18, historical financing mechanisms for DPHs included the following:

- Assembly Bill 85 (AB 85, Chapter 24, Statutes of 2013) required cost-based reimbursement of county DPHs for services provided to Optional Expansion beneficiaries.
- Senate Bill 208 (SB 208, Chapter 714, Statutes of 2010) required cost-based reimbursement of county DPHs and participating University of California (UC) systems for services provided to Seniors and Persons with Disabilities who were mandatorily transitioned to the Medi-Cal managed care delivery system.

On May 6, 2016, CMS issued the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which at the time was the first major update to federal managed care regulations concerning Medicaid and CHIP in more than a decade.[1] Among other changes, the final rule prohibited states from directing payments to providers through managed care contracts except under specified circumstances. Broadly, the final rule limited allowable direction of managed care payments to instances of:

- Value-based purchasing models (e.g. pay-for-performance, bundled payments);
- Delivery system reform or performance improvement initiatives; and
- Minimum/maximum fee schedules, or uniform dollar/percentage increases.

Existing hospital pass-through payments, which the final rule defined in a manner that included the cost-based reimbursement mechanisms under AB 85 and SB 208, were deemed unallowable direction of payment and required to be phased out over a period of no more than 10 years. Additionally, on January 18, 2017, CMS issued another final rule which capped existing hospital pass-through payments at levels in effect as of July 5, 2016.[2]

In response to the new federal regulations, SB 171 (Chapter 768, Statutes of 2017) effectuated two new directed payment programs intended, in part, to continue support for DPHs in order to maintain access and improve quality of care for Medi-Cal beneficiaries.

- Welfare and Institutions Code (WIC) section 14197.4(b) requires DHCS to direct Plans to increase reimbursements, on uniform dollar and/or percentage basis, to DPHs for contract services. For the SFY 2017-18 service period, this new directed payment program, the EPP, is expected to result in supplemental payments to DPHs totaling approximately $1.5 billion, subject to final approval by CMS.
- WIC section 14197.4(c) requires DHCS to direct Plans to pay performance-based quality incentive payments to DPHs based on DHCS's evaluation of DPHs' performance on specified quality measures. For the SFY 2017-18 service period, this Quality Incentive Program (QIP) is expected to result in supplemental payments to DPHs totaling approximately $640 million, subject to final approval by CMS.

This toolkit, and the associated encounter volume charts, are applicably only to the EPP.

[1] See Federal Register Document Number 2016-09581, available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

[2] See Federal Register Document Number 2017-00916, available at https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery.

EPP: Structure and Policy

Final EPP payments will be implemented using a multi-pool approach across five classes of DPHs, as outlined in the table below.

- DPHs in a capitated pool will receive specific uniform percentage increases to payments for capitated contract arrangements.
- DPHs in fee-for-service (FFS) pools will receive specific uniform dollar increases to payments for specified categories of services, segmented into two sub-pools:
    1. Inpatient/Long-Term Care (LTC)
    2. Non-Inpatient

Provider Class	DPH systems	Capitated Pool?	FFS Pool?
A	San Francisco Health Network	YES	YES
	Santa Clara Valley Medical Center		
B	Alameda Health System	NO	YES
	Arrowhead Regional Medical Center		
	Kern Medical		
	Natividad Medical Center		
	Riverside University Health System		
	Ventura County Medical Center		
C	Contra Costa Regional Medical Center	NO	YES
	San Joaquin General Hospital		
	San Mateo Medical Center		
D	University of California Systems	NO	YES
E	LA County Department of Health Services	YES	YES

Due to implementation considerations, each pool is subdivided into two equal halves:

- Phase I, for the service period of July 1, 2017 through December 31, 2017.
- Phase II, for the service period of January 1, 2018 through June 30, 2018.

Additionally, final EPP payments will be based on the actual utilization of contract services as reflected in the Medi-Cal managed care encounter data received by DHCS. Therefore, while DHCS will initially develop proxy per-member-per-month (PMPM) rate add-on amounts for the EPP based on projected expenditures in SFY 2017-18, pursuant to the EPP proposal approved by CMS, these proxy PMPMs will not be paid. For the final EPP payments, DHCS will adjust (recalculate) the rate add-on amounts based on the actual distribution of Inpatient/LTC and Non-Inpatient utilization (for FFS pools) or member assignment (for capitated pools).

Note: Only contract services are eligible for EPP payments. (see Contract Services for details).

Exclusions

The following services are excluded from the EPP:

- Inpatient services provided to enrollees with Medicare Part A, and Non-Inpatient services provided to enrollees with Medicare Part B.
- Services provided to enrollees with Other Health Coverage.
- Services provided by the following:
    1. Cost-Based Reimbursement Clinics (CBRCs)
    2. Indian Health Care Providers (IHCPs)

3. Federally Qualified Health Centers (FQHCs)
4. Rural Health Clinics (RHCs)

- **Update 10-19-2018:** State-only abortion services.[3]

Where a hospital and CBRC, FQHC, IHCP, or RHC share the same NPI, Inpatient, Emergency Room (ER) and Outpatient Facility (OP) encounters are no longer zeroed out because of the NPI. Inpatient and ER encounters are counted as normal, and OP encounters are counted if they do not have a Provider Type Code of 35 or 75.

Contract Services

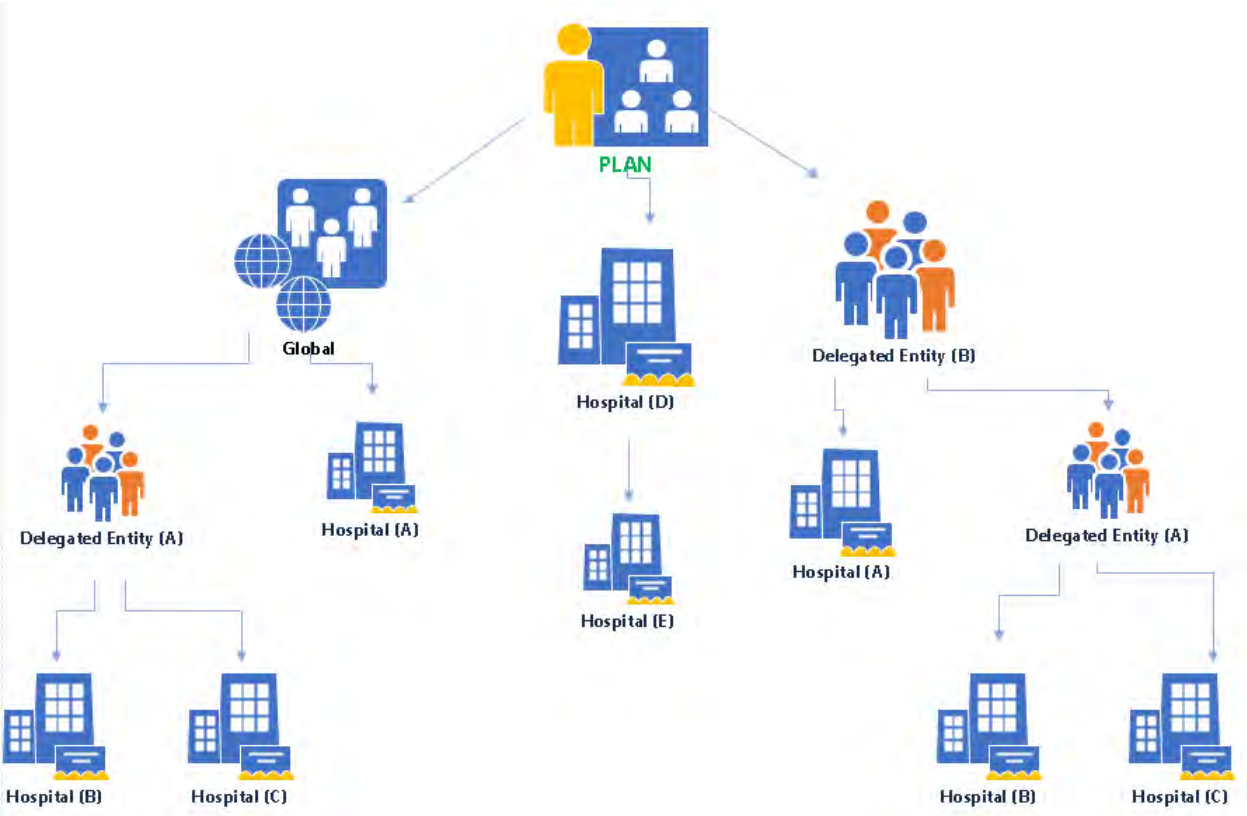
Update 10-19-2018: For purposes of the EPP, a contract service is a Medi-Cal covered service rendered to a beneficiary actively enrolled in a Plan by an eligible hospital pursuant to a contractual arrangement that meets the minimum criteria outlined in the following notice for the applicable date(s) of service:
https://www.dhcs.ca.gov/services/Documents/DirectedPymts/DHCS_MEMO_Hospital_DP_Definition_20181005.pdf

For SFY 2017-18, the minimum criteria for an agreement include but are not limited to:

Agreement MUST	**Agreement MUST NOT**
Cover one or more defined non-excluded populations of Medi-Cal beneficiaries	Be limited to a single patient only
Cover a defined set of one or more non-excluded hospital services	Be limited to treatment of a single case or instance only
Specify rates of payment or include a defined methodology for calculating specific rates of payment	Permit payment to be negotiated on a per patient or single instance of service basis
Be for a set duration of at least 120 days	Expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement

Note: Additional guidance on processes and requirements for reporting contract data to DHCS will be provided at a later date.

[3] State-only abortion services are identified by one of the following procedure codes: 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, X7724, X7726, Z0336, 01964, or 01966.



Contracting Examples

- ***Example 1:***
  Hospital A has a full-risk capitation agreement with a Plan to care for a specific population. Hospital A also has a contract with Hospital B to provide quaternary care to that population when the service is not available at Hospital A. Hospital B receive payment directly from Hospital A for treating this population.

  A) If Hospital B is not contracted with the Plan, are they considered a network provider when providing quaternary services for this population?

  Yes, for the specific population and for quaternary services.

  B) If Hospital B is contracted with the Plan, but for a different population, are they considered a network provider when providing quaternary services for this population?

  Yes, for the specific population and for quaternary services.

- ***Example 2:***
  Hospital A has a contract with an Independent Physicians Association (IPA) to provide ancillary services. If a patient from the IPA presents to the hospital's emergency room and is ultimately admitted as an inpatient for treatment, is Hospital A considered a network provider?

  No for inpatient services; **Yes** for ancillary services.

- ***Example 3:***
  Hospital A has a contract with IPA A to treat their patient population with a Plan. Hospital A does not have a contract with IPA B to treat their population with the Plan. Is Hospital A considered a network provider when they treat members of IPA B?

  No. Hospital A is contracted for IPA A's population only.

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Update 10-19-2018:

- ***Example 4***:
  Hospital A has a one-year contract (as defined above) with a Plan to care for a specific population. Hospital A terminates the contract after 90 days. Does this contract meet the requirements under the contracting definition?

  Yes. The term of the agreement was for a period of at least 120 days. However, only services provided during the 90 days under contract would be counted.

EPP: Implementation Timeline

In order to meet federal timely claim filing deadlines, DHCS must make EPP payments to Plans no later than September 30, 2019 for Phase I, and no later than March 31, 2020 for Phase II. Therefore, and considering both encounter system lags and the time needed to perform calculations, any additional or revised encounter data must be received by DHCS **no later than December 31, 2018 for Phase I**, and **no later than June 30, 2019 for Phase II**, to be considered during the calculation of final EPP payments. Encounter data must be submitted through existing, established processes, and DHCS is unable to accept data submitted through a supplemental process.

Note: DHCS anticipates Plans will communicate specific encounter data submission deadlines that are earlier than the due dates noted above. DPHs and Plans are expected to work together to determine these specific deadlines.

See the graphic below for an overview of the full EPP implementation timeline.

	ACTIVITY	Q4 CY2018	Q1 CY2019	Q2 CY2019	Q3 CY2019	Q4 CY2019	Q1 CY2020
Phase I	Deadline for Encounter Data Submission to Health Plans	Exact Due Dates are Plan Specific					
	Deadline for Encounter Data Submission to DHCS	December 31, 2018					
	Final Encounter Data Pull for Payment Calculation		March 2019				
	Development of Rate Adjustments			Q2 CY2019			
	Finalization of Rate Adjustments				July 1, 2009		
	Notice of Final Payment Amounts				August 2019		
	Projected Payment to Plans				September 2019		
Phase II	Deadline for Encounter Data Submission to Health Plans			Exact Due Dates are Plan Specific			
	Deadline for Encounter Data Submission to DHCS			June 30, 2019			
	Final Encounter Data Pull for Payment Calculation				September 2019		
	Development of Rate Adjustments					Q4 CY2019	
	Finalization of Rate Adjustments						January 1, 2020
	Notice of Final Payment Amounts						February 2020
	Projected Payment to Plans						March 2020

Note: Additional guidance on processes and requirements for reporting contract data to DHCS will be provided at a later date.

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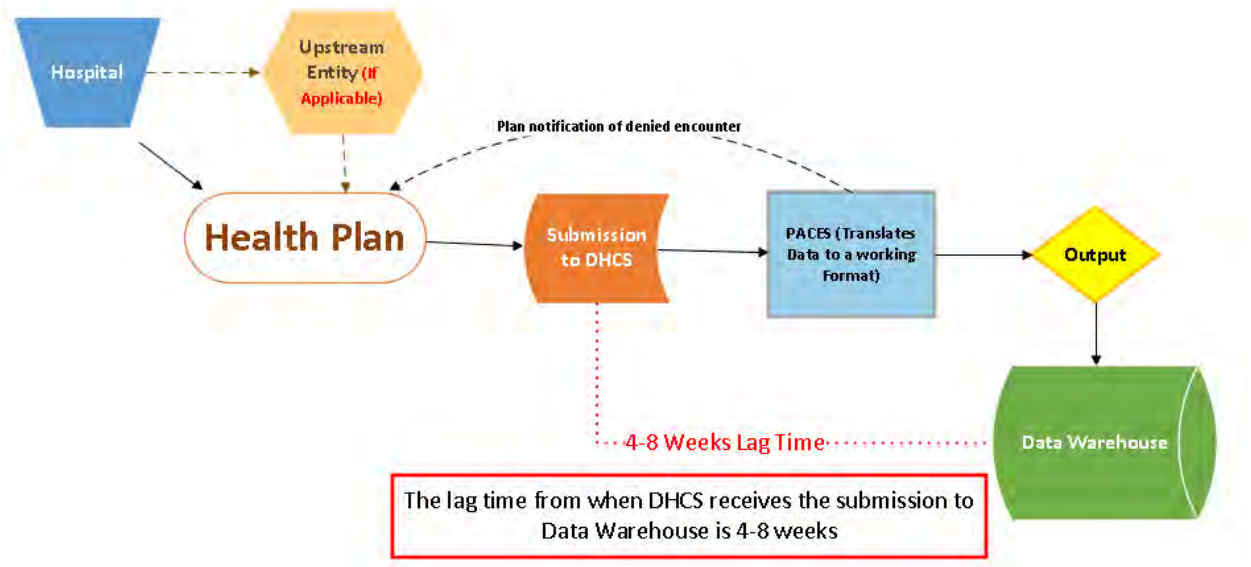
Encounter Data Flow

Encounters are generated by the provider of the service and transmitted, either directly or indirectly through an upstream entity, to the Plan. Once encounters are received, the Plan applies appropriate system edits and submits accepted encounters to DHCS, where the encounter system translates the incoming encounters into a working format that can be queried and used for statistical analysis and reporting. See the chart below for a visual representation of encounter data flow.



There is a 4–8-week lag (approximately) between the time Plans submit encounter data to DHCS and the time DHCS is able to query the encounter data for inclusion in encounter volume charts. As a result, encounter data submitted to DHCS within approximately 8 weeks of the date of the encounter volume chart likely will not be represented.

Update 10-19-2018:
For further background information, please see the Standard Companion Guide Transaction Information released by DHCS, which details how encounter data is transacted once received in DHCS' systems:
https://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Documents/2.02%20834%205010%20Documents/2.02_WEDI_X12_5010_834_CG_TIv3_1v2.pdf

Also, below is a link to DHCS' managed care contract boilerplates:
https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

Counting Logic

Services are counted in accordance with the logic described in Appendix B subject to the caveats indicated below.

Inpatient Hospital days are equal to the Discharge Date (INPAT_DISCHARGE_DT) minus the Service From Date (SVC_FROM_DT). If the two fields contain the same date, the day count is set equal to "1". If INPAT_DISCHARGE_DT is blank, the Service To Date (SVC_TO_DT) is used instead.

For inpatient stays that span the beginning or end of either of the two SFY 2017-18 EPP phases (July 1, 2017 through December 31, 2017, and January 1, 2018 through June 30, 2018), only the portion of "earned days" occurring during the service period are counted. For example, for Phase I:

Service From Date	Discharge Date	Day Difference	Service Count
07/01/2017	07/01/2017	0	1
07/01/2017	07/02/2017	1	1
07/01/2017	07/03/2017	2	2
06/30/2017	07/01/2017	1	0
06/29/2017	07/02/2017	3	1
12/31/2017	01/01/2018	1	2
12/30/2017	01/02/2018	3	3

For **delivery-related inpatient stays**, the service count is equal to the lesser of:

- The value of the INPAT_DAYS_STAY field; or
- Twice the difference of INPAT_DISCHARGE_DT minus SVC_FROM_DT.
    - If the two fields contain the same date, the day count is set equal to "2".
    - If INPAT_DISCHARGE_DT is blank, SVC_TO_DT is used instead.

Delivery-related inpatient stays are identified as follows:

- PROC_CD is equal to one of the following: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59610, 59612, 59614, 59510, 59514, 59515, 59525, 59618, 59620, 59622
  OR
- REVENUE_CD is equal to one of the following: 720, 721, 722, 724, 729
  OR
- PRIMARY_DIAG_CD_ICD10 is equal to one of the following: 0TQDXZZ, 0DQP0ZZ, 0DQP3ZZ, 0DQP4ZZ, 0DQP7ZZ, 0DQP8ZZ, 0DQR0ZZ, 0DQR3ZZ, 0DQR4ZZ, 0UQG0ZZ, 0UQG3ZZ, 0UQG4ZZ, 0UQG7ZZ, 0UQG8ZZ, 0UQGXZZ, 0UQM0ZZ, 0UQMXZZ, 0WQNXZZ, 0UJD7ZZ, 0W3R0ZZ, 0W3R3ZZ, 0W3R4ZZ, 0W3R7ZZ, 0W3R8ZZ, 2Y44X5Z, 0JCB0ZZ, 0JCB3ZZ, 0UCG0ZZ, 0UCG3ZZ, 0UCG4ZZ, 0UCM0ZZ, 0US90ZZ, 0US94ZZ, 0US9XZZ, 10H003Z, 10H00YZ, 10P003Z, 10P00YZ, 10P073Z, 10P07YZ, O6010X0, O6010X1, O6010X2, O6010X3, O6010X4, O6010X5, O6010X9, O6012X0, O6012X1, O6012X2, O6012X3, O6012X4, O6012X5, O6012X9, O6013X0, O6013X1, O6013X2, O6013X3, O6013X4, O6013X5, O6013X9, O6014X0, O6014X1, O6014X2, O6014X3, O6014X4, O6014X5, O6014X9, O6020X0, O6020X1, O6020X2, O6020X3, O6020X4, O6020X5, O6020X9, O6022X0, O6022X1, O6022X2, O6022X3, O6022X4, O6022X5, O6022X9, O6023X0, O6023X1, O6023X2, O6023X3, O6023X4, O6023X5, O6023X9, O670, O678, O679, O68, O690XX0, O690XX1, O690XX2, O690XX3, O690XX4, O690XX5, O690XX9, O691XX0, O691XX1, O691XX2, O691XX3, O691XX4, O691XX5, O691XX9, O692XX0, O692XX1, O692XX2, O692XX3, O692XX4, O692XX5, O692XX9, O693XX0, O693XX1, O693XX2, O693XX3, O693XX4, O693XX5, O693XX9, O694XX0, O694XX1, O694XX2, O694XX3, O694XX4, O694XX5, O694XX9, O695XX0, O695XX1, O695XX2, O695XX3, O695XX4, O695XX5, O695XX9, O6981X0, O6981X1, O6981X2, O6981X3, O6981X4, O6981X5, O6981X9, O6982X0, O6982X1, O6982X2, O6982X3, O6982X4, O6982X5, O6982X9, O6989X0, O6989X1, O6989X2, O6989X3, O6989X4, O6989X5, O6989X9, O699XX0, O699XX1, O699XX2, O699XX3, O699XX4, O699XX5, O699XX9, O700, O701, O702, O703, O704, O709, O720, O721, O722, O723, O730, O731, O740, O741, O742, O743, O744, O745, O746, O747, O748, O749, O750, O751, O752, O753, O754, O755, O7581, O7582, O7589, O759, O76, O770, O771, O778, O779, O778, O779

For non-Inpatient/LTC visits, a visit is counted for each unique combination of patient (AKA_CIN), provider (NPI), and date of service (Service From Date).

- For Emergency Room, Specialty Physician, Primary Care Physician, and Other Medical Professional services, the header-level date of service on the encounter record is used.
- For Outpatient Facility and Mental Health Outpatient services, the detail-level date of service on the encounter record is used. This is intended to account for recurring visits where multiple visits are reported on one claim or encounter, such as for a series of physical therapy visits.

Questions

For questions, please contact:

- DPHs – PublicDP@dhcs.ca.gov
- Plans – PlanDP@dhcs.ca.gov

This toolkit and the statewide directory of DPH and Plan contacts will be posted on DHCS's public website in the near future. Links will be provided at a later date.

Appendix A: Encounter Volume Chart Release Schedule

Volume Chart Release Date	NPI Cutoff Date	Encounter Data Received by DHCS as of … (est.)	Data for:
June 29, 2018	N/A	March-April 2018	July 1, 2017 – December 31, 2017
August 17, 2018	July 27, 2018	May 2018	July 1, 2017 – February 28, 2018
October 12, 2018	September 28, 2018	Early August 2018	July 1, 2017 – April 30, 2018
November 9, 2018	October 26, 2018	Early September 2018	July 1, 2017 – June 30, 2018

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Appendix B: Volume Chart Data Elements

Update 10-19-2018:

Note: The following fields were populated with an "X" if they were left blank in the Summary Files.

OC_CD
CLAIM FORM IND
FI_CLAIM_TYPE_CD
FI_PROV_TYPE_CD
PROV SPEC CD
PROV_TAXON
POS_CD
REVENUE_CD
VENDOR_CD

Update 10-19-2018: Organized data elements alphabetically and added new elements and descriptions as appropriate.

ADJ_IND -

Code	Description
	Not an adjustment
1	Positive Supplemental
2	Negative Supplemental (negative only)
3	Refund to Medi-Cal (negative only)
4	Positive side of void and reissue
5	Negative side of void and reissue
6	Cash disposition (obsolete)

ADMIT_FAC_NPI - Admitting Facility NPI (from Claims)

AGE - Age of Beneficiary

AKA_CIN - Actual non-masked CIN Number

BENE_FIRST_NAME - Beneficiary First Name

BENE_LAST_NAME - Beneficiary Last Name

BENE_BIRTH_DT - Beneficiary Birth Date

BILL_TYPE_CD - A four-digit numeric code which identifies the specific type of bill (inpatient, outpatient, adjustments, voids, etc.). The first digit represents Type of Facility, the second digit the Bill Classification, and the third digit the Frequency. The first and second positions are separated from the third by the qualifier.

BIRTH_DT - Birth Date

CCN - CMS' Certification Number (CCN), is the hospital's identification number and is linked to its Medicare provider agreement.

CHECK_DT - Check Issue Date

CLAIM_FORM_IND - Identifies if the claim form used is a UB-92 or a HCFA-1500 form

CLINIC_TYPE - Generated field based on a specified list of NPIs

FQ – Federally Qualified Health Centers
RH – Rural Health Clinic
IH – Indian Health Service
CB – Cost Based Reimbursement Clinics
NA – None of the Above

DTL_SVC_FROM_DT - Detail Service From Date

DTL_SVC_TO_DT - Detail Service To Date

ENCRYPTED_AKA_CIN - Encrypted CIN

FI_CLAIM_TYPE_CD -

Code	Description
	Unknown
01	Pharmacy
02	Long Term Care
03	Hospital Inpatient
04	Outpatient
05	Medical/Allied
06	Code not used at DHCS
07	Vision
09	Code not used at DHCS
5	Unknown
55	Unknown
AP	Advanced Payment (No Provider) (IHSS)
CC	Contract County Provider (IHSS)
IP	Individual Provider (IHSS)
RM	Restaurant & Meals (No Provider) (IHSS)

FI_PROV_TYPE_CD -

Code	Description
	UNKNOWN
000	UNKNOWN
001	ADULT DAY HEALTH CARE CENTERS
002	ASSISTIVE DEVICE AND SICK ROOM SUPPLY DEALERS
003	AUDIOLOGISTS

004	BLOOD BANKS
005	CERTIFIED NURSE MIDWIFE
006	CHIROPRACTORS
007	CERTIFIED NURSE PRACTIONER
008	CHRISTIAN SCIENCE PRACTIONER
009	CLINICAL LABORATORIES
010	GROUP CERTIFIED NURSE PRACTITIONER
011	FABRICATING OPTICAL LABORATORY
012	DISPENSING OPTICIANS
013	HEARING AID DISPENSERS
014	HOME HEALTH AGENCIES
015	COMMUNITY OUTPATIENT HOSPITAL
016	COMMUNITY INPATIENT HOSPITAL
017	LONG TERM CARE FACILITY
018	NURSE ANESTHETISTS
019	OCCUPATIONAL THERAPISTS
020	OPTOMETRISTS
021	ORTHOTISTS
022	PHYSICIANS GROUP
023	GROUP OPTOMETRISTS
024	PHARMACIES/PHARMACISTS
025	PHYSICAL THERAPISTS
026	PHYSICIANS
027	PODIATRISTS
028	PORTABLE X-RAY
029	PROSTHETISTS
030	GROUND MEDICAL TRANSPORTATION
031	PSYCHOLOGISTS
032	CERTIFIED ACUPUNTURIST
033	GENETIC DISEASE TESTING
034	MEDICARE CROSSOVER PROVIDER ONLY
035	RURAL HEALTH CLINICS/FEDERALLY QUALIFIED HEALTH CENTER
036	UNKNOWN
037	SPEECH THERAPISTS
038	AIR AMBULANCE TRANSPORTATION SERVICES
039	CERTIFIED HOSPICE
040	FREE CLINIC
041	COMMUNITY CLINIC
042	CHRONIC DIALYSIS CLINIC
043	MULTISPECIALTY CLINIC
044	SURGICAL CLINIC
045	CLINIC EXEMP FROM LICENSURE
046	REHABILITATION CLINIC

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047	UNKNOWN
048	COUNTY CLINICS NOT ASSOCIATED WITH HOSPITAL
049	BIRTHING CENTER SERVICES
050	OTHERWISE UNDESIGNATED CLINIC
051	OUTPATIENT HEROIN DETOX CENTER
052	ALTERNATIVE BIRTH CENTERS - SPECIALTY CLINIC
053	EVERY WOMAN COUNTS
054	EXPANDED ACCESS TO PRIMARY CARE
055	LOCAL EDUCATION AGENCY
056	RESPIRATORY CARE PRACTITIONER
057	EPSDT SUPPLEMENTAL SERVICES PROVIDER
058	HEALTH ACCESS PROGRAM
059	HOME AND COMMUNITY BASED SERVICES NURSING FACILITY
060	COUNTY HOSPITAL INPATIENT
061	COUNTY HOSPITAL OUTPATIENT
062	GROUP RESPIRATORY CARE PRACTITIONERS
063	LICENCED BUILDING CONTRACTORS
064	EMPLOYMENT AGENCY
065	PEDIATRIC SUBACUTE CARE/LTC
066	PERSONAL CARE AGENCY
067	RVNS INDIVIDUAL NURSE PROVIDERS
068	HCBC BENEFIT PROVIDER
069	PROFESSIONAL CORPORATION
070	LICENSED CLINICAL SOCIAL WORKER INDIVIDUAL
071	LICENSED CLINICAL SOCIAL WORKER GROUP
072	MENTAL HEALTH INPATIENT SERVICES
073	AIDS WAIVER SERVICES
074	MULTIPURPOSE SENIOR SERVICES PROGRAM
075	INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT
076	DRUG MEDI-CAL
077	MARRIAGE AND FAMILY THERAPIST INDIVIDUAL
078	MARRIAGE AND FAMILY THERAPIST GROUP
080	CCS/GHPP NON-INSTITUTIONAL
081	CCS/GHPP INSTITUTIONAL
082	LICENSED MIDWIVES
084	INDEPENDENT DIAGNOSTIC TESTING FACILITY XOVER PROV ONLY
085	CLINICAL NURSE SPECIALIST X-OVER PROVIDER ONLY
086	MEDICAL DIRECTORS
087	LICENSED PROFESSIONALS
089	ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM
090	OUT OF STATE
092	RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)
093	CARE COORDINATOR (CCA).

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095	PRIVATE NON-PROFIT PROPRIETARY AGENCY
098	UNKNOWN
099	UNKNOWN

HOSPITAL_NAME - Name of Hospital

HOSPITAL_SYSTEM - The names of the Hospitals derived based on NPIs

INPAT_ADMISSION_DT - Admission Date identifies the date the patient was admitted to the hospital (Inpatient and LTC claims only).

INPAT_DAYS_STAY - Inpatient Days Stay is only populated for inpatient and Long Term Care claims.

INPAT_DISCHARGE_DT - Discharge Date identifies the date the patient was discharged (Inpatient and LTC claims only).

INPAT_DISCHARGE_DT_FLAG - If =1, the blank INPAT_DISCHARGE_DT was populated with SVC_TO_DT

MAIN_SGMNT_ID_NO - Claim Line Number

MC_HDR_MEDI_CAL_PAID_AMT - Header Paid Amount

MC_STAT_A OR MC_STAT_B -

Code	Description
	No coverage
0	No coverage
1	Paid for by beneficiary
2	Paid for by State Buy-In
3	Free (Part A only)
4	Paid by state other than California
5	Paid for by Pension Fund
6	UNKNOWN
7	Presumed eligible
8	UNKNOWN
9	Aged alien ineligible for Medicare

Full Duals must meet both criteria:

- Medicare Indicator A – 1, 2, 3, 4, or 5
- Medicare Indicator B – 1, 2, 4 or 5

MC_STAT_D - Indicates an enrollee's Medicare Part D status

MEDICARE_STATUS -

Full Dual – Both Medicare Part A and Part B
MC_Part_A – Medicare Part A

MC Part B – Medicare Part B
MCal_only – No Medicare

MEDI_CAL_REIMB_AMT - Detail Paid Amount

NPI - National Provider Number (from Claims Header)

OC_CD - Identifies the Other Health Coverage (OC) circumstances for each service rendered

Value	Description
	No Coverage
2	Provident Life and Accident (no longer in use)
3	Principal Financial Group (no longer in use)
4	Pacific Mutual Life Insurance (no longer in use)
6	AARP (no longer in use)
9	Healthy Families
A	Any Carrier (includes multiple coverage), pay and chase
B	Blue Cross (no longer in use)
C	CHAMPUS Prime HMO
D	Medicare Part D
E	Plans Limited to Vision Coverage
F	Medicare Risk HMO (formerly First Farwest)
G	CDCR Medical Parolee Plan (formerly American General)
H	Multiple Plans Comprehensive
I	Public Institution Coverage (formerly Metropolitan Life)
K	Kaiser
L	Dental only policies
M	Two or more carriers (no longer in use)
N	No Coverage
O	Override - Used to remove cost avoidance OHC codes posted by DHS Recovery or data matches (OHC Source is H, R, or T). Changes OHC to A.
P	PHP/HMOs and EPO (Exclusive Provider Option) not otherwise specified
Q	Pharmacy Plans Only(Non-Medicare)
R	Ross Loos (no longer in use)
S	Blue Shield (no longer in use)
T	Travelers (no longer in use)
U	Connecticut General (no longer in use)
V	Any carrier other than above, includes multiple coverage (formerly Variable)
W	Multiple Plans Non-Comprehensive
X	Blue Shield (no longer in use)
Y	Blue Cross North (no longer in use)
Z	Blue Cross South (no longer in use)

PAT_CTL_NBR – Patient Control Number. Identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment.

PLAN_CD - Plan Code from Eligibility Table

PLAN_CAP_AID_CD - Aid Codes based on capitation payments

PLAN_NAME - Health Plan Name

POS_CD - Point of Service Code

POS_CD	***Description***
0	Emergency Room
1	Inpatient Hospital
2	Outpatient Hospital
3	Nursing Facility, Level A/B
4	Home
5	Office, Lab, Clinic
6	ICF-DD
7	Other

PRIMARY_DIAG_CD - Primary Diagnosis Code

PRIMARY_DIAG_CD_ICD10 - Primary Diagnosis Coded for ICD-10.

PROC_CD - Procedure Code

PROC_IND -

Code	Description
	EDS Inpatient long-term care (LTC) Note: the procedure code field is a space, so the accommodation code is used.
0	DELTA Dental Table of Dental Procedures (prior to 7/1/93 when HCPCS [Health Care Financing Administration Common Procedure coding system] replaced them)
1	UB-92s ([Uniform Billing - 1992] Uniform Billing codes began on January 1, 1992.)
2	SMA [Scheduled Maximum Allowance] (replaced by HCPCS Levels II and III except for special rural health clinic/federally qualified health center codes) Note: EPSDT (Early Periodic Screening, Diagnosis and Treatment) claims always use this indicator.
3	UPC (Universal Product Code), PIN (Product Identification Number), HRI (Health Related Item), NDC (National Drug Code) codes for drugs, NDC medical supply codes and state drug code IDs for Medical Supplies. SEE F35B-MEDICAL-SUPPLY-INDICATOR and F35B-PROCE
4	CPT-4 (as of 11/1/87 -- Current Procedure Terms: A systematic listing and coding of healthcare procedures and services performed by clinicians. The American Medical Associations CPT-4 refers to procedures delivered by physicians.)
5	Unknown
6	California Health Facilities Commission (CHFC)
7	Los Angeles Waiver/L. A. Waiver
8	Short-Doyle/Medi-Cal (only on Plan Code 8)
9	HCPCS Levels II and III (effective on October 1, 1992)

PROV_SPEC_CD – Provider Specific Code

Code	Description
	Unknown
	Unknown
0	Unknown
1	Unknown
2	Unknown
3	Unknown
4	Unknown
5	Unknown
6	Unknown
7	Unknown
8	Unknown
#N	Unknown
*G	Unknown
*N	Unknown
00	General Practioner (Dentists Only)
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease (M.D. only)
07	Dermatology
08	Family Practice
09	Gynecology (D.O. only)
0X	UNKNOWN
1	Unknown
10	Gastroenterology (M.D. only), Oral Surgeon (Dentists Only)
11	Aviation (M.D. only)
12	Manipulative Therapy (D.O. only)
13	Neurology (M.D. only)
14	Neurological Surgery
15	Obstetrics (D.O. only), Endodontist (Dentists Only)
16	Obstetrics-Gynecology (M.D. Only) Neonatal
17	Ophthalmology, Otolaryngology, Rhinology (D.O. only)
18	Ophthalmology
19	Dentists (DMD)
1A	Unknown
1B	Unknown
1C	Unknown
1G	Unknown

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1Y	Unknown
2	Nurse Practitioner (non-physician medical practitioner)
20	Orthopedic Surgery, Orthodontist (Dentists Only)
21	Pathologic Anatomy: Clinical Pathology (D.O. only)
22	Pathology (M.D. only)
23	Peripheral Vascular Disease or Surgery (D.O. only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation, Certified Orthodontist (Dentists Only)
26	Psychiatry (child)
27	Psychiatry Neurology (D.O. only)
28	Proctology (colon and rectal)
29	Pulmonary Diseases (M.D. only)
2X	Unknown
3	Physician Assistant (non-physician medical practitioner)
30	Radiology, Pedodontist (Dentists Only)
31	Roentgenology, Radiology (M.D. only)
32	Radiation Therapy (D.O. only)
33	Thoracic Surgery
34	Urology and Urological Surgery
35	Pediatric Cardiology (M.D. only)
36	Psychiatry
37	Unknown
38	Geriatrics
39	Preventive (M.D. only)
4	Nurse Midwife (non-physician medical practitioner)
40	Pediatrics, Periodontist (Dentists Only)
41	Internal Medicine
42	Nuclear Medicine
43	Pediatric Allergy
44	Public Health
45	Nephrology (Renal-Kidney)
46	Hand Surgery
47	Miscellaneous
48	Unknown
49	Unknown
5	Unknown
50	Prosthodontist (Dentists Only)
51	Unknown
52	Unknown
53	Unknown
54	Unknown
55	Unknown
56	Unknown

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57	Unknown
58	Unknown
59	Unknown
6	Unknown
60	Oral Pathologist (Dentists Only)
61	Unknown
62	Unknown
63	Unknown
64	Unknown
65	Unknown
66	Emergency Medicine (Urgent Care)
67	Endocrinology
68	Hematology
69	Unknown
6Y	Unknown
7	Unknown
70	Clinic (mixed specialty), Public Health (Dentists Only)
71	Unknown
72	Unknown
73	Unknown
74	Unknown
75	Unknown
76	Unknown
77	Infectious Disease
78	Neoplastic Diseases/Oncology
79	Neurology-Child
7A	Unknown
8	Unknown
80	Full-Time Facility (Dentists Only)
81	Unknown
82	Unknown
83	Rheumatology
84	Surgery-Head and Neck
85	Surgery-Pediatric
86	Unknown
87	Unknown
88	Unknown
89	Surgery-Traumatic
9	Unknown
90	Pathology-Forensic
91	Pharmacology-Clinical
92	Unknown
93	Marriage, family and child counselor

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94	Licensed clinical social worker
95	Registered nurse
96	Unknown
97	Unknown
98	Unknown
99	Unknown (on EDS claims)

PROV_TAXON - Billing Provider taxonomy identifies the provider type, classification, and specialization for the billing provider (Claims Header Information).

RECORD_ID - Record Identification Number provides a unique number for each claim header record.

- **Update 10-19-2018:** The first four digits of RECORD_ID indicate the year and month the Plan submitted the encounter record to DHCS. For example, if a Plan submitted the encounter record on August 19, 2018, the first four digits would be listed as 1808.

REF_PRESC_NPI - Referring Prescribing NPI (from Claims Detail)

REMOVE_NOTE - The reason a service count was removed i.e. (Full Duals, Part A or B, Other Coverage, NA)

REMOVE_SVC_CNT - A DHCS derived field that indicates how many units of service have been subtracted. This subtraction removes services performed at a CBRC, FQHC, IHCP, or RHC. It also removes services provided to enrollees with other health coverage as well as inpatient services provided to enrollees with Medicare Part A, and Non-Inpatient services provided to enrollees with Medicare Part B.

REND_OPERATING_NPI - Rendering Operating NPI (from Claims Detail)

REVENUE_CD - Revenue Code

SEC_DIAG_CD - Secondary Diagnosis Code

SEC_DIAG_CD_ICD10 - Secondary Diagnosis Code for ICD-10 identifies a patient's secondary diagnosis, which requires supplementary medical treatment.

SVC_CAT - Category of Service (COS) groups

SVC_CAT	Description
S01_IP	Inpatient Hospital
S02_ER	Emergency Room
S03_OP	Outpatient Facility
S04_LTC	Long-Term Care
S05_SP	Physician Specialty
S06_PCP	Physician Primary Care
S07_MHOP	Mental Health - Outpatient
S08_NPP	Other Medical Professional
S09_FQHC	FQHC
S10_OTH	All Other

COS is based on the COS grouping logic and hierarchy. For example, inpatient (S01) has a higher hierarchy than outpatient (S02). If a record meets both the criteria for inpatient and outpatient, that record will be classified as inpatient. See Appendix C for more details.

SVC_CNT - Service unit count (see Appendix C)

SVC_FROM_DT - Header Service From Date

SVC_TO_DT - Header Service To Date

SVC_UNITS_NBR - Service Units

VENDOR_CD -

Code	Description
	Unknown
M	INVALID
0	Unknown
00	INVALID
01	Adult Day Health Care Centers
02	Medicare Crossover Provider Only
03	CCS / GHPP
04	Genetic Disease Testing
05	Certified Nurse Midwife
06	Certified Hospice Service
07	Certified Pediatric NP
08	Certified Family NP
09	Respiratory Care Practitioner
1	UNKNOWN
10	Licensed Midwife Program
11	Fabricating Optical Labs
12	Optometric Group
13	Nurse Anesthetist
14	Expanded Access to Primary Care
16	INVALID
19	Portable X-ray Lab
2	INVALID
20	Physicians (MD or DO)
21	Ophthalmologist (San Joaquin Foundation only)
22	Physicians Group
23	Lay Owned Lab Services(RHF)
24	Clinical Lab
25	INVALID
26	Pharmacies
27	Dentist

28	Optometrist
29	Dispensing Optician
30	Chiropractor
31	Psychologist
32	Podiatrist
33	Acupuncturist
34	Physical Therapist
35	Occupational Therapist
36	Speech Therapist
37	Audiologist
38	Prosthetist
39	Orthotist
40	Other Provider (non-prof. prov svcs)
41	Blood Bank
42	Medically Required Trans
44	Home Health Agency
45	Hearing Aid Dispenser
47	Intermediate Care Facility-Developmentally Disabled
49	Birthing Center
5	INVALID
50	County Hosp - Acute Inpatient
51	County Hosp - Extended Care
52	County Hosp - Outpatient
53	Breast Cancer Early Detection Program
55	Local Education Agency
56	State Developmental Centers
57	State Hosp - Mentally Disabled
58	County Hosp - Hemodialysis Center
59	County Hosp - Rehab Facility
6	UNKNOWN
60	Comm Hosp - Acute Inpatient
61	Comm Hosp - Extended Care
62	Comm Hosp - Outpatient
63	Mental Health Inpatient Consolidation
64	Short Doyle Comm MH - Hosp Svcs
68	Comm Hosp - Renal Dialysis Center
69	Comm Hosp - Rehab Facility
70	Acute Psychiatric Hosp
71	Home/Comm Based Service Waivers
72	Surgicenter
73	AIDS Waiver Services
74	Short Doyle Comm MH Clinic Svcs
75	Organized Outpatient Clinic

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76	DDS Waiver Services
77	Rural Health Clinics/FQHCs/Indian Health Clinics
78	Comm Hemodialysis Center
79	Independent Rehabilitation Facility
8	Unknown
80	Nursing Facility (SNF)
81	MSSP Waiver Services
82	EPSDT Supplemental Services
83	Pediatric Subacute Rehab/Weaning
84	Assist. Living Waiver Pilot Project (ALWPP)
87	INVALID
88	Self-Directed Services(SDS) Waiver Services
89	Personal Care Services Program (IHSS)
9	Unknown
90	Others and Out-of-State
91	Outpat Heroin Detox
92	Medi-Cal Targeted Case Management
93	DDS Targeted Case Management
94	CHDP Provider
95	Short Doyle Comm MH - Rehab Treatment
99	INVALID
A1	INVALID
B1	INVALID
CQ	Unknown
DN	Unknown
NF	Unknown
OD	INVALID
OE	INVALID
OG	INVALID
OH	INVALID
OL	INVALID
OM	INVALID
OO	INVALID
OS	INVALID
OT	INVALID
PA	Unknown
PC	Unknown
PS	Unknown
XX	INVALID

Appendix C: Category of Service Groupings - Mapping Logic

Notes for COS Mapping Logic:

1. DHCS groups data into different Categories of Service (COS). Below is a description of the hierarchy used to identify each of the COS.
2. Logic Format Notes: 1) All bullet points under each criteria must be met to satisfy that criteria. 2) For COS where there are multiple criteria, there is a line hat reads: "Criteria Combinations". This line explains which criteria need to be met in order to satisfy the requirement for assignment to the COS. For example, if the line reads "Criteria Combinations - (1,2) or (1,3) or (1,4)", then if criteria 1 AND 2, or 1 AND 3, or 1 AND 4 are met, then the claim should be assigned to the COS.
3. The categories of service are listed in hierarchical order and should be followed when claims meet criteria for more han one COS. For example, if a claim meets criteria for both Inpa ient and Emergency Room, the claim would be assigned to Inpatient because Inpatient is listed higher on the hierarchy than Emergency Room.
4. Any one claim/encounter is classified into only one COS. Therefore, if a claim has multiple detail lines with varying COS assignments, use the hierarchy to decide the COS to which the entire claim will be assigned.
5. Crossover claims should be reported in their corresponding COS.

Inpatient Hospital

Unit Type	Unit type special instructions
Days	One inpatient stay per calendar day per member for "earned days" occuring during the service period (Day Count = INPAT_DISCHARGE_DT − SVC_FROM_DT; when SVC_FROM_DT = INPAT_DISCHARGE_DT, then Day Count = 1)

Description: Facility-related expenses for hospital inpatient services, including room, board, and ancillary charges.
- **Includes** any Emergency Room facility charges for individuals who are admitted to the hospital on an inpatient basis.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).
- **Excludes** outpatient and Emergency Room (that does not result in an inpatient admission)
- **Excludes** LTC

Criteria #1
- **CLAIM FORM IND** = "U"
- **FI CLAIM TYPE CD** = "03" (Inpatient Hospital)

Criteria #2
- **INPAT DISCHARGE DT** or **SVC TO DT** > **SVC FROM DT**

Criteria #3
- **Provider Type Codes**
  - 60 - County Hospital Inpatient
  - 72 - Mental Health Inpatient
  - 16 - Community Hospital Inpatient

Criteria #4
- **INPAT DAYS STAY** ≥ 1

Criteria Combinations - (1,2) or (1,3) or (1,4)

Community-Based Adult Services (CBAS)

Unit Type	Unit type special instructions
Days	Do not count more than one day as a unit per calendar day per member

Description: All expenses related to services provided by a CBAS center. CBAS replaced the former Adult Day Health Care program effective April 1, 2012.
- **Includes** both the per day CBAS costs as well as CBAS assessment costs.
- **Excludes** LTC facility costs as they are reported in the LTC facility COS line.

Criteria #1
- **Vendor Codes**
  - 01 - Adult Day Health Care Centers

Criteria #2
- **Procedure Codes**
  - H2000 - Comp multidisipln evaluation
  - S5102 - Adult day care per diem
  - T1023 - Program intake assessment
  - S5100 - day care services, adult per 15 minutes
  - S5101 - day care services, adult per half day

Criteria Combinations - (1) or (2)

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Emergency Room

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and facility (NPI)

Description: All facility-related expenses of an Emergency Room visit that did not result in an inpatient admission.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).
- After applying all COS logic, look for any OP facility claims occurring on the same day a member had an ER professional claim and reclassify these from OP Facility COS to ER COS

Criteria #1
- Claims with **FI CLAIM TYPE CD** = 04 (Outpatient)

Criteria #2
- **POS CD** = 0 (Emergency Room)

Criteria #3
- PROC_CD of Z7502, 99281, 99282, 99283, 99284, or 99285

Criteria #4
- Revenue Code of 450, 451, 452, 453, 454, 455, 456, 457, 458, or 459

Criteria Combinations - (1,2) or (1,3) or (1,4)

Outpatient Facility

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (DTL_SVC_FROM_DT), and provider (NPI)

Description: All facility-related expenses incurred for outpatient services.
- **Excludes** Emergency Room
- **Includes** all facility-related costs for non-inpatient services from a hospital or other outpatient facilities such as an ambulatory surgery center.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).

Criteria #1
- **Provider Type Codes**

61 - County Hospital Outpatient	15 - Community Hospital Outpatient Departments
49 - Birthing Centers-Primary Care Clinics	52 - Alternative Birth Centers- Specialty Clinics
44 - Surgical Clinics	42 - Chronic Dialysis Clinics

Criteria #2
- **FI CLAIM TYPE CD** = 04 (Outpatient)
- **Provider Type Codes**

60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

Criteria #3
- **FI CLAIM TYPE CD** = 02 (Long Term Care) or 03 (Hospital Inpatient)
- **POS CD** = 2 (Outpatient Hospital) or 5 (Office, Lab, Clinic)

Criteria #4
- **FI PROV TYPE CD** = 50 (Clinic-otherwise undesignated)
- **Provider Taxonomy Codes**

261QX0200X	261QP3300X

Criteria Combinations - (1) or (2) or (3) or (4)

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Behavioral Health Treatment (BHT)

Unit Type	Unit type special instructions
Hours	Best estimate of number of service hours

Description: All expenses related to BHT services such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that prevent or minimize the adverse effects of Autism Spectrum Disorder (ASD). Services include, but are not limited to:
- Comprehensive Diagnostic Evaluation (CDE)
- Behavioral assessment
- Treatment planning
- Delivery of evidence based BHT services
- Training of parents/guardians
- Case management

Criteria #1:

- **Member Age** = Less han 21

Criteria #2: Codes that trigger a BHT supplemental payment

Procedure Codes
H0031 - Mh health assess by non-md
H0032 - Mh svc plan dev by non-md
H0046 - Mental health service nos
H2012 - Behav hlth day treat per hr
H2014 - Skills train and dev 15 min
H2019 - Ther behav svc per 15 min
S5111 - Home care training family per session

Criteria #3: Codes that reflect BHT services, but do not trigger a BHT supplemental payment. The cost for these services will be included in the BHT supplemental payment amount.

Procedure Codes	
0364T - Behavior treatment	0370T - Fam behav treatment guidance
0365T - Behavior treatment addl	0371T - Mult fam behav treat guide
0366T - Group behavior treatment	0372T - Social skills training group
0367T - Group behav treatment addl	0373T - Exposure behavior treatment
0368T - Behavior treatment modified	0374T - Fam behav treatment guidance
0369T - Behav treatment modify addl	

*Please include any other CPT codes your health plan uses for BHT services. The goal here is to most accurately report the BHT services of individuals diagnosed with Autism.

Criteria #4: Comprehensive Diagnostic Evaluation (CDE) services performed with he intent to determine medical necessity

Procedure Codes	
90791 - Psych diagnostic evaluation	96119 - Neuropsych tst by technician
90792 - Psych diag eval w/med srvcs	96120 - Neuropsych tst admin w/comp
96101 - Psycho testing by psych/phys	90785 - Interactive complexity
96102 - Psycho testing by technician	0359T - Behavioral id assessment
96103 - Psycho testing by computer and psych	0360T - Observ behav assessment
96105 - Assessment of aphasia	0361T - Observ behav assess addl
96111 - Developmental Testing Extended	0362T - Expose behav assessment
96116 - Neurobehavioral status exam	0363T - Expose behav assess addl
96118 - Neuropsych tst by psych/phys	

Criteria Combinations - (1,2) or (1,3) or (1,4 - with he intent to determine medical necessity)

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Mental Health - Outpatient

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (DTL_SVC_FROM_DT), and provider (NPI)

Description: All expenses for professional services related to the carve-in of mental health services for individuals with mild/moderate mental health needs/conditions. Services accounted for here are those provided by a Psychiatrist and/or other mental health non-physician professionals (e.g. Psychologist, LCSW, etc.).
- **Includes** mental health services provided in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Tribal Clinic.
- **Excludes** SBIRT (Screening, Brief Intervention, and Referral to Treatment). These services should be reported under PCP.
- **Excludes** Behavioral Health Treatment (BHT) services as defined in the BHT category of service.

Criteria #1

Provider Specialty Codes	
26 - Psychiatry (child)	36 - Psychiatry
27 - Psychiatry Neurology (D.O. only)	

Criteria #2

Provider Type Codes	
31 - Psychologists	34 - Licensed Clinical Social Worker (LCSW)

Criteria #3

Procedure Codes	
90833 - Psytx 30 minutes	90836 - Psytx 45 minutes
90838 - Psytx 60 minutes	Z0300 Individual medical psychotherapy by a physician
90785 - Interactive complexity	90791 - Psych diagnostic evaluation
90792 - Pysch diagnostic evaluation w/medical services	90832 - Psytx pt&/family 30 minutes
90834 - Psytx pt&/family 45 minutes	90837 - Psytx pt&/family 60 minutes
90839 - Psytx crisis initial 60 min	90840 - Psytx crisis ea addl 30 min
90845 - Psychoanalysis	90846 - Family Psychotherapy
90847 - Family psychotherapy 50 minutes	90849 - Multi-Family/Group psychotherapy
90853 - Group psychotherapy	96101 - Psycho testing by psych/phys
96105 - Assessment of aphasia	96110 - Developmental screen w/score
96111 - Developmental test extend	96116 - Neurobehavioral status exam
96118 - Neuropsych tst by psych/phys	96120 - Neuropsych tst admin w/comp
99366 - Team conf w/pat by hc prof	99368 - Team conf w/o pat by hc pro

Criteria #4

- **FI_PROV_TYPE_CD** = 50 (Clinic-otherwise undesignated)

Provider Taxonomy Codes	
261QM0855X	261QM0850X
261QM0801X	261QM2800X

Criteria #5

- **FI_PROV_TYPE_CD** = 57 (EPSDT Supplemental Services Provider)

Provider Taxonomy Codes	
NOT = 225700000X	NOT = 2255A2300X

Criteria Combinations - (1) or (2) or (3) or (4) or (5)

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Long-Term Care

Unit Type	Unit type special instructions
Days	Count only one long term care facility stay per calendar day per member (Day Count = INPAT_DISCHARGE_DT − SVC_FROM_DT + 1)

Description: All facility-related expenses of a long-term care facility stay (e.g. skilled nursing home, hospital with a skilled nursing unit, or intermediate care facility)
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).

Criteria #1

Provider Type Codes	
17 - Long Term Care	65 - Pediatric Subacute Care - LTC

Criteria #2

Vendor Codes	
47 - Intermediate Care Facility - Developmentally Disabled	80 - Nursing Facility (SNF)

Criteria #3
- **FI CLAIM TYPE CD** = 02 (Long Term Care)

Criteria #4

Provider Type Codes	
60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

Criteria #5

Vendor Codes	
50 - County Hospital - Acute Inpatient	51 - County Hospital - Extended Care
60 - Community Hospital - Acute Inpatient	61 - Community Hospital - Extended Care
63 - Mental Health Inpatient Consolidation	

Criteria #6
- **FI PROV TYPE CD** = 50 (Clinic-otherwise undesignated)
- **INPAT DAYS STAY** > 0

Criteria #7
- **VENDOR CD** = 40 (Other provider - non-prof. provider services)
- **INPAT DAYS STAY** > 0

Criteria #8
- **FI CLAIM TYPE CD** = 02 (Long Term Care) or 03 (Hospital Inpatient)
- **POS CD** = 3 (Nursing Facility, Level A/B) or 6 (ICF-DD)

Criteria Combinations - (1) or (2) or (3,4) or (3,5) or (3,6) or (3,7) or (8)

Federally Qualified Health Center (FQHC)

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC FROM DT), and provider (NPI)

Description: All expenses for services provided in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tr bal Health Clinic, or Los Angeles County Cost Based Reimbursement Clinic (CBRC).
- **Excludes** mental health services as defined in the 'Mental Health - Outpatient' category of service.

Criteria #1

Provider Type Codes	
35 - P L. 95-210 Rural Health Clinics and Federally Qualified Health Centers (FQHCs)	75 - Tribal Health Clinic

Criteria #2

Place of Service Codes	
50 - Federally Qualified Health Center	72 - Rural Health Clinic

Criteria #3
- **FI PROV TYPE CD** = 50 (Clinic-otherwise undesignated)

Provider Taxonomy Codes	
261Q00000X	261QP0904X

Criteria Combinations - (1) or (2) or (3)

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Specialty Physician

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and provider (NPI)

Description: All fee-for-service and contracted services provided by certain physician types (based on the provider specialty code) not included elsewhere.
- **Excludes** services provided in an FQHC.
- **Excludes** mental health services as defined in the 'Mental Health - Outpatient' category of service.

Criteria #1

- **Provider Type Codes**

22 - Physicians Group	26 - Physicians

- **PROV_SPEC_CD**

05 - Anesthesiology	23 - Peripheral Vascular Disease or Surgery (D.O. only)
07 - Dermatology	03 - Allergy
06 - Cardiovascular Disease/Cardiology (M.D. only)	28 - Proctology (colon and rectal)
67 - Endocrinology & Metabolism	66 - Emergency Medicine
68 - Hematology	10 - Gastroenterology (M.D. Only)
02 - General Surgery	77 - Infectious Disease
29 - Pulmonary Disease (M D. only)	45 - Nephrology
14 - Neurological Surgery	83 - Rheumatology
13 - Neurology (M.D. only)	42 - Nuclear Medicine
79 - Neurology-Child	20 - Orthopedic Surgery
18 - Ophthalmology	21 - Pathology Anatomy: Clinical Pathology (D.O. Only)
17 - Ophthalmology Ototolaryngology Rhinology (D.O. only)	22 - Pathology (M D. Only)
43 - Pediatric Allergy	90 - Pathology-Forensic
35 - Pediatric Cardiology (M.D. only)	25 - Physical Medicine & Rehabilitation
24 - Plastic Surgery	33 - Thoracic Surgery
32 - Radiation Therapy (D.O. only)	91 - Pharmacology Clinical
84 - Surgery-Head and Neck	31 - Roentgenology, Radiology (D.O. only)
85 - Surgery-Pediatric	04 - Otology, Laryngology, Rhinology (ENT)
89 - Surgery-Traumatic	78 - Neoplastic Diseases
34 - Urology and Urological Surgery	16 - Obstetrics-Gynecology (MD Only) Neonatal

Criteria #2

- **FI_CLAIM_TYPE_CD** = 05 (Medical)
- **Provider Type Codes**

60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

- **PROV_SPEC_CD**

05 - Anesthesiology	23 - Peripheral Vascular Disease or Surgery (D.O. only)
07 - Dermatology	03 - Allergy
06 - Cardiovascular Disease/Cardiology (M.D. only)	28 - Proctology (colon and rectal)
67 - Endocrinology & Metabolism	66 - Emergency Medicine
68 - Hematology	10 - Gastroenterology (M.D. Only)
02 - General Surgery	77 - Infectious Disease
29 - Pulmonary Disease (M D. only)	45 - Nephrology
14 - Neurological Surgery	83 - Rheumatology
13 - Neurology (M.D. only)	42 - Nuclear Medicine
79 - Neurology-Child	20 - Orthopedic Surgery
18 - Ophthalmology	21 - Pathology Anatomy: Clinical Pathology (D.O. Only)
17 - Ophthalmology, Ototolaryngology, Rhinology (D.O. only)	22 - Pathology (M D. Only)
43 - Pediatric Allergy	90 - Pathology-Forensic
35 - Pediatric Cardiology (M.D. only)	25 - Physical Medicine & Rehabilitation
24 - Plastic Surgery	33 - Thoracic Surgery
32 - Radiation Therapy (D.O. only)	91 - Pharmacology Clinical
84 - Surgery-Head and Neck	31 - Roentgenology Radiology (D.O. only)
85 - Surgery-Pediatric	04 - Otology Laryngology Rhinology (ENT)
89 - Surgery-Traumatic	78 - Neoplastic Diseases
34 - Urology and Urological Surgery	16 - Obstetrics-Gynecology (MD Only) Neonatal

Criteria #3

- **FI_PROV_TYPE_CD** = 50 (Clinic-otherwise undesignated)
- **Provider Taxonomy Codes**

261QM1300X	261QX0200X
261QE0800X	261QM2500X

Criteria Combinations - (1) or (2) or (3)

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Primary Care Physician

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and provider (NPI)

Description: Services provided by all physician types (who were not classified as a specialty physician and did not provide the service in a FQHC). Includes contracted and fee-for-service expenses for practitioners where members receive routine preventive and urgent care treatment from an assigned clinic or primary care provider. Outside of an FQHC setting, this expense category should include such services delivered regardless of place of service (such as within a hospital or other facility).
- **Includes** Early and Periodic Screening, Diagnosis and Treatment (EPSDT).
- **Includes** Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- **Includes** drugs administered in a physician's office if the costs are attached to the physician claim.

Criteria #1

- **Provider Type Codes**

22 - Physicians Group	26 - Physicians
41 - Community Clinics	

Criteria #2

- **FI_PROV_TYPE_CD** = 50 (Clinic-otherwise undesignated)
- **Provider Taxonomy Codes**

261QP0905X	261QM1000X
261QH0100X	261QM1100X
261QC1800X	261QM1101X
261QP2300X	261QV0200X

Criteria #3

- **FI_PROV_TYPE_CD** = 98 (Miscellaneous)
- **Provider Taxonomy Codes**

251K00000X

Criteria Combinations - (1) or (2) or (3)

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Other Medical Professional

Unit Type	Unit type special instructions
Services	Count of the claim detail lines

Description: All expenses related to services provided (outside of an FQHC) by non-physician professionals who are not classified as Physician Primary Care or Physician Specialty (e.g. Certified Nurse Practitioners, Nurse Midwives, therapists, etc.)
- **Excludes** mental health services as defined in the 'Mental Health - Outpatient' category of service.

Criteria #1

Provider Type Codes	
07 - Certified Pediatric Nurse & Certified Nurse	29 - Prosthetists
10 - Group Certified Pediatric NP & Certified Family NP	56 - Respiratory Care Practitioner
62 - Group Respiratory Care Practitioner	23 - Optometric Group
18 - Nurse Anesthetists	12 - Dispensing Opticians
06 - Chiropractor	27 - Podiatrists
32 - Certified Acupuncture	25 - Physical Therapists
19 - Occupational Therapists	37 - Speech Therapist
03 - Audiologist	21 - Orthotists
05 - Certified nurse midwife	20 - Optometrists

Criteria #2

PROV_SPEC_CD	
2 - Nurse Practitioner	3 - Physician Assistant
4 - Nurse Midwife	

Criteria #3

- **FI_PROV_TYPE_CD** = 50 (Clinic-otherwise undesignated)

Provider Taxonomy Codes	
261QF0050X	261QX0100X
261QI0500X	261QP2000X
261QP2000X	261QP1100X
261QA0005X	261QA0900X
261QH0700X	261QA3000X
261QL0400X	261QD1600X
261QA0006X	

Criteria #4

- **FI_PROV_TYPE_CD** = 98 (Miscellaneous)

Provider Taxonomy Codes	**Provider Taxonomy Codes**
363A00000X	367500000X
251C00000X	174400000X

Criteria #5

- **FI_PROV_TYPE_CD** = 13 (Hearing Aid Dispensers)

Provider Taxonomy Codes	**Provider Taxonomy Codes**
237600000X	237700000X

Criteria Combinations - (1) or (2) or (3) or (4) or (5)

Other

Unit Type	Unit type special instructions
Varies	Varies

Description: All other MCO-covered medical services not grouped in another category of service, such as Hospice, Multipurpose Senior Services Program, In-Home Supportive Services, Home and Community Based Services Other, Lab and Radiology, Pharmacy, Transportation, and All Other.

Appendix D: Crosswalk of Plan Names to Health Care Plan Codes

Plan Name	County	Plan Code	Region
Aetna	Sacramento	15	GMC
	San Diego	16	GMC
United	Sacramento	17	GMC
	San Diego	18	GMC
Alameda Alliance for Health	Alameda	300	Two-Plan
Anthem	Alpine	100	Regional
	Amador	101	Regional
	Butte	102	Regional
	Calaveras	103	Regional
	Colusa	104	Regional
	El Dorado	105	Regional
	Glenn	106	Regional
	Inyo	107	Regional
	Mariposa	108	Regional
	Mono	109	Regional
	Nevada	110	Regional
	Placer	111	Regional
	Plumas	112	Regional
	Sierra	113	Regional
	Sutter	114	Regional
	Tehama	115	Regional
	Tuolumne	116	Regional
	Yuba	117	Regional
	Fresno	362	Two-Plan
	Tulare	311	Two-Plan
	Alameda	340	Two-Plan
	San Francisco	343	Two-Plan
	Contra Costa	344	Two-Plan
	Kings	363	Two-Plan
	Madera	364	Two-Plan
	San Benito	144	Regional
	Sacramento	190	GMC
	Santa Clara	345	Two-Plan
CalOptima	Orange	506	COHS
CalViva Health	Fresno	315	Two-Plan
	Kings	316	Two-Plan
	Madera	317	Two-Plan

Plan Name	County	Plan Code	Region
CA Health & Wellness	Imperial	143	Regional
	Tehama	139	Regional
	Tuolumne	141	Regional
	Alpine	118	Regional
	Amador	119	Regional
	Butte	120	Regional
	Calaveras	121	Regional
	Colusa	122	Regional
	El Dorado	123	Regional
	Glenn	124	Regional
	Inyo	128	Regional
	Mariposa	129	Regional
	Mono	133	Regional
	Nevada	134	Regional
	Placer	135	Regional
	Plumas	136	Regional
	Sierra	137	Regional
	Sutter	138	Regional
	Yuba	142	Regional
Care 1st	San Diego	167	GMC
CenCal	San Luis Obispo	501	COHS
	Santa Barbara	502	COHS
Central CA Alliance for Health	Merced	514	COHS
	Santa Cruz	505	COHS
	Monterey	508	COHS
Community Health Group	San Diego	29	GMC
Contra Costa HP	Contra Costa	301	Two-Plan
Gold Coast HP	Ventura	515	COHS
Health Net	Los Angeles	352	Two-Plan
	Tulare	353	Two-Plan
	San Joaquin	354	Two-Plan
	Kern	360	Two-Plan
	Sacramento	150	GMC
	San Diego	68	GMC
	Stanislaus	361	Two-Plan

Plan Name	County	Plan Code	Region
HP of San Joaquin	San Joaquin	308	Two-Plan
	Stanislaus	312	Two-Plan
HP of San Mateo	San Mateo	503	COHS
Inland Empire HP	Riverside	305	Two-Plan
	San Bernardino	306	Two-Plan
Kaiser	Sacramento	170	GMC
	San Diego	79	GMC
	Amador	177	Regional
	Placer	179	Regional
	El Dorado	178	Regional
Kern Health Systems	Kern	303	Two-Plan
LA Care HP	Los Angeles	304	Two-Plan
Molina	Sacramento	130	GMC
	Imperial	145	Regional
	San Diego	131	GMC
	Riverside	355	Two-Plan
	San Bernardino	356	Two-Plan
Partnership Health Plan	Marin	510	COHS
	Napa	507	COHS
	Solano	504	COHS
	Yolo	509	COHS
	Sonoma	513	COHS
	Mendocino	512	COHS
	Lake	511	COHS
	Humboldt	517	COHS
	Lassen	518	COHS
	Modoc	519	COHS
	Shasta	520	COHS
	Siskiyou	521	COHS
	Trinity	522	COHS
	Del Norte	523	COHS
San Francisco Health Plan	San Francisco	307	Two-Plan
Santa Clara Family HP	Santa Clara	309	Two-Plan

Appendix E: Change Log

Changes from Previous Versions			
ID	**Change Description**	**Toolkit Section**	**Version Date**
1	Updated SFTP access link	Volume Charts	08/2018
2	Added encounter volume chart release details	Volume Charts	08/2018
3	Added phased implementation	EPP: Structure and Policy	08/2018
4	Added NPI & LTC update	Exclusions	08/2018
5	Updated implementation schedule	EPP: Implementation Timeline	08/2018
6	Updated data release schedule	Appendix A	08/2018
7	Added more fields and descriptions	Appendix B	08/2018
8	Added Appendix E: Change Log	Appendix E	08/2018
9	Added Appendix F: Sample Encounter Volume Chart	Appendix F	08/2018
10	Identified State-only abortion services as an excluded service category	Exclusions	10/2018
11	Added new contracting service definition guidance	Contract Services	10/2018
12	Added links to Companion Guide and Managed Care contract boilerplates	Encounter Data	10/2018
13	Added new Counting Logic section	Counting Logic	10/2018
14	Added new data elements and descriptions as appropriate; various organizational changes	Appendix B	10/2018
15	Clarified unit type special instructions	Appendix C	10/2018
16	Removed procedure code Z7500, in combination with FI_CLAIM_TYPE_CD '04' (Outpatient), as an indicator of ER	Appendix C	10/2018

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Appendix F: Sample Encounter Volume Chart

ABC Community Hospital Volume Pivot Chart (Data for July 1, 2017 - December 31, 2017)

Sum of SVC_CNT			SVC_CAT			
Hospital_Name	NPI	PLAN_CD	S01_IP	S02_ER	S03_OP	Grand Total
ABC_COMMUNITY_HOSP	12345678	1000	181	516	6	703
		1002		10	0	10
		1004	1	34	0	35
		1006		1	0	1
		1008	127	113	0	240
		1010	0	3	0	3
		1012	0	9	0	9
		1014		1		1
		1050	0	7	1	8
		2000	0			0
		3600		2	0	2
	12345678 Total		309	696	7	1012
	98765432	1000	0			0
		1008	0		0	0
	98765432 Total		0		0	0
ABC_COMMUNITY_HOSP Total			309	696	7	1012
Grand Total			309	696	7	1012

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SFY 2017-18 Private Hospital Directed Payment Program
Volume Chart Review Toolkit
Version: October 19, 2018

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Summary

The Department of Health Care Services (DHCS) is implementing the state fiscal year (SFY) 2017-18 Private Hospital Directed Payment Program (PHDP), applicable to qualifying services during the service period of July 1, 2017 through June 30, 2018. The PHDP was approved in concept by the federal Centers for Medicare & Medicaid Services (CMS) on March 6, 2018, and provides supplemental reimbursement to participating hospitals based on the actual utilization of qualifying services, as reflected in Medi-Cal managed care encounter data reported to DHCS.

To assist the ongoing PHDP implementation efforts, DHCS will periodically provide encounter volume charts to participating hospitals and Medi-Cal managed care plans (Plans) for Medi-Cal managed care utilization associated with the National Provider Identifiers (NPIs) reported by hospitals. The volume charts are intended to facilitate discussions between hospitals and Plans to ensure the accuracy and completeness of the encounter data.

Purpose

The purpose of this document is to provide the information needed to interpret and evaluate the encounter volume charts, such as data definitions and logic, as well as guidance related to reviewing encounter data and information about the PHDP policy overall. This toolkit will be posted on DHCS's public website: http://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx The toolkit will be periodically updated as necessary, and updates will be recorded in a change log (see Appendix E).

Additional resources, including a statewide directory of hospital and Plan contacts, will also be posted on DHCS's public website at the same location and periodically updated.

Volume Charts

DHCS will save your organization's encounter volume chart(s) on a Secure File Transfer Protocol (SFTP) site accessible through this link: https://etransfer.dhcs.ca.gov/.

Follow the steps below to retrieve your organization's encounter volume chart(s):

1. Have your organization's designated SFTP Contact(s) log in to the SFTP site using their assigned user login and selected password.

2. If accessing the SFTP site for the first time using the temporary password provided by DHCS, immediately change the temporary password to a unique password.

3. In the upper left corner of the front page, click "Folders".

4. Click to open the "DHCS-CRDD-HospitalFinancing" folder.

5. Click to open either the "Private Hospitals" folder (for hospitals only) or the "Health Plans" folder (for Plans only).

6. Click to open the folder(s) corresponding to your organization.

7. Transfer the two files to your organization's servers. The files are:
    a. An encounter volume chart (summary counts) in a pivot table format, and
    b. A raw data file (encounter-level detail including Protected Health Information) in tab delimited format (see Appendix B).
        i. This file includes all Medi-Cal managed care utilization for the applicable service period associated with your organization based on the NPIs reported by hospitals, including utilization associated with excluded services (see PHDP: Structure and Policy).

DHCS anticipates providing encounter volume charts on multiple occasions; the current encounter volume chart release schedule is outlined in Appendix A. For a sample of an encounter volume chart, please see Appendix F.

The data releases will consist of four files: a detail (.tab) file and a summary (.xlsx) file for Phase I (July 1, 2017 through December 31, 2017) and a detail and a summary file for the portion of Phase II we are presently releasing (January 1, 2018 through February 28, 2018).

Review Steps for Hospitals

If you identify material differences between the service counts reflected on your encounter volume chart(s) and your anticipated service counts, follow these steps:

1. Are the differences related to Plans (see Appendix D) with which you were contracted (either directly or indirectly through a delegated arrangement) to provide qualifying services during the applicable service period?
    a. If no, do not proceed, as these services are not eligible for PHDP payments.
    b. If yes, proceed to step 2.

2. Are you comparing utilization for the same service period covered by the encounter volume chart(s)?
    a. If no, align to the service period covered by the encounter volume chart(s).
    b. If yes, proceed to step 3.

3. Is your service logic aligned with the encounter volume chart logic (see Appendix C)?
    a. If no, align to DHCS' encounter volume chart logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.

4. Are you applying the appropriate exclusions (see PHDP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS's counting logic.
    b. If yes, proceed to step 5.

5. Are the differences related to NPIs that are missing from the encounter volume chart(s)?
    a. If no, proceed to step 6.
    b. If yes, verify the NPI is not related to an excluded provider type (i.e. CBRC, FQHC, IHCP, or RHC).
        i. If there is still a variance, notify DHCS at PrivateDP@dhcs.ca.gov in order to report the missing NPI(s) and troubleshoot the issue.
        ii. Once you have notified DHCS, proceed to step 6 for NPIs that are included in the encounter volume chart(s).

6. Are your anticipated service counts still materially different from the service counts reflected on your encounter volume chart(s)?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.

7. Work with your affected Plan partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected Plan partner(s) able to identify and resolve the data deficiencies?
    a. If no, proceed to step 8
    b. If yes, no further action is needed.

    Note: Discrepancies may be due to multiple factors such as: (i) the Plan did not receive encounters (or required data was missing); (ii) the Plan did not submit encounters to DHCS; and (iii) encounters were rejected by DHCS's system edits.

8. Contact DHCS at PrivateDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Review Steps for Plans

If you identify material differences between the service counts reflected on your encounter volume chart and your anticipated service counts, follow these steps:

1. Are the differences related to hospitals with which you were contracted (either directly or indirectly through a delegated arrangement) for qualifying services during the applicable service period?
    a. If no, do not proceed, as these services are not eligible for PHDP payments.
    b. If yes, proceed to step 2.

2. Are you comparing utilization for the same service period covered by the encounter volume chart?
    a. If no, align to the service period covered by the encounter volume chart.
    b. If yes, proceed to step 3.

3. Is your service logic aligned with DHCS's encounter volume chart logic (see Appendix C)?
    a. If no, align to DHCS' encounter volume chart logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.

    Note: The encounter volume chart logic is not the same as the RDT logic.

4. Are you applying the appropriate exclusions (see PHDP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS's counting logic.
    b. If yes, proceed to step 5.

5. Are the differences related to NPIs that are missing from the encounter volume chart?
    a. If no, proceed to step 6.
    b. If yes, notify the hospital that the NPI is not included in the encounter volume chart, and then proceed to step 6 for NPIs that are included.

6. Are your anticipated service counts still materially different from the service counts reflected on your encounter volume chart?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.

7. Work with your hospital partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected hospital partner(s) able to identify and resolve the data deficiencies?
    c. If no, proceed to step 8
    d. If yes, no further action is needed.

    Note: Discrepancies may be due to multiple factors such as: (i) the Plan did not receive encounters (or required data was missing); (ii) the Plan did not submit encounters to DHCS; and (iii) encounters were rejected by DHCS's system edits.

8. Contact DHCS at PlanDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Background

Prior to SFY 2017-18, historical financing mechanisms for private hospitals included the Hospital Quality Assurance Fee (HQAF) program, which increased capitation payments made to Plans to reimburse for hospital services provided to Medi-Cal enrollees.

On May 6, 2016, CMS issued the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which at the time was the first major update to federal managed care regulations concerning Medicaid and CHIP in more than a decade.[1] Among other changes, the final rule prohibited states from directing payments to providers through managed care contracts except under specified circumstances. Broadly, the final rule limited allowable direction of managed care payments to instances of:

- Value-based purchasing models (e.g. pay-for-performance, bundled payments);
- Delivery system reform or performance improvement initiatives; and
- Minimum/maximum fee schedules, or uniform dollar/percentage increases.

Existing hospital pass-through payments, which the final rule defined in a manner that included the HQAF program, were deemed unallowable direction of payment and required to be phased out over a period of no more than 10 years. Additionally, on January 18, 2017, CMS issued another final rule which capped existing hospital pass-through payments at levels in effect as of July 5, 2016.[2]

In response to the new federal regulations, and to continue support for private hospitals in order to maintain access and improve quality of care for Medi-Cal beneficiaries, DHCS is implementing two statewide private hospital financing programs for SFY 2017-18:

- The pre-existing HQAF program, which is deemed a pass-through payment under the final rule, will continue and be subject to the 10-year phasedown. For the SFY 2017-18 service period, this program is expected to result in supplemental payments to private hospitals totaling approximately $1.8 billion, subject to final approval by CMS.
- The new directed payment program, PHDP, implements a uniform dollar increase to reimbursements to private hospitals for contract services. For the SFY 2017-18 service period, the PHDP is expected to result in supplemental payments to private hospitals totaling $2.1 billion, subject to final approval by CMS.

This toolkit, and the associated encounter volume charts, are applicably only to the PHDP.

PHDP: Structure and Policy

Final PHDP payments will be implemented using a statewide pool approach, with separate sub-pools for:

- Inpatient services
- Hospital Outpatient and Emergency Room services

Due to implementation considerations, each pool is subdivided into two equal halves:

- Phase I, for the service period of July 1, 2017 through December 31, 2017.

[1] See Federal Register Document Number 2016-09581, available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
[2] See Federal Register Document Number 2017-00916, available at https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery.

- Phase II, for the service period of January 1, 2018 through June 30, 2018.

Additionally, final PHDP payments will be based on the actual utilization of contract services as reflected in the Medi-Cal managed care encounter data received by DHCS. Therefore, while DHCS will initially develop proxy per-member-per-month (PMPM) rate add-on amounts for the PHDP based on projected expenditures in SFY 2017-18, pursuant to the PHDP proposal approved by CMS, these proxy PMPMs will not be paid. For the final PHDP payments, DHCS will adjust (recalculate) the rate add-on amounts based on the actual distribution of Inpatient and Hospital Outpatient/Emergency Room utilization.

Note: Only contract services are eligible for PHDP payments. (see Contract Services for details).

Exclusions

The following services are excluded from the PHDP:

- Inpatient services provided to enrollees with Medicare Part A, and Non-Inpatient services provided to enrollees with Medicare Part B.
- Services provided to enrollees with Other Health Coverage.
- Services provided by the following:
    1. Cost-Based Reimbursement Clinics (CBRCs)
    2. Indian Health Care Providers (IHCPs)
    3. Federally Qualified Health Centers (FQHCs)
    4. Rural Health Clinics (RHCs)
- **Update 10-19-2018:** State-only abortion services.[3]

Where a hospital and CBRC, FQHC, IHCP, or RHC share the same NPI, Inpatient, Emergency Room (ER) and Outpatient Facility (OP) encounters are no longer zeroed out because of the NPI. Inpatient and ER encounters are counted as normal, and OP encounters are counted if they do not have a Provider Type Code of 35 or 75.

Contract Services

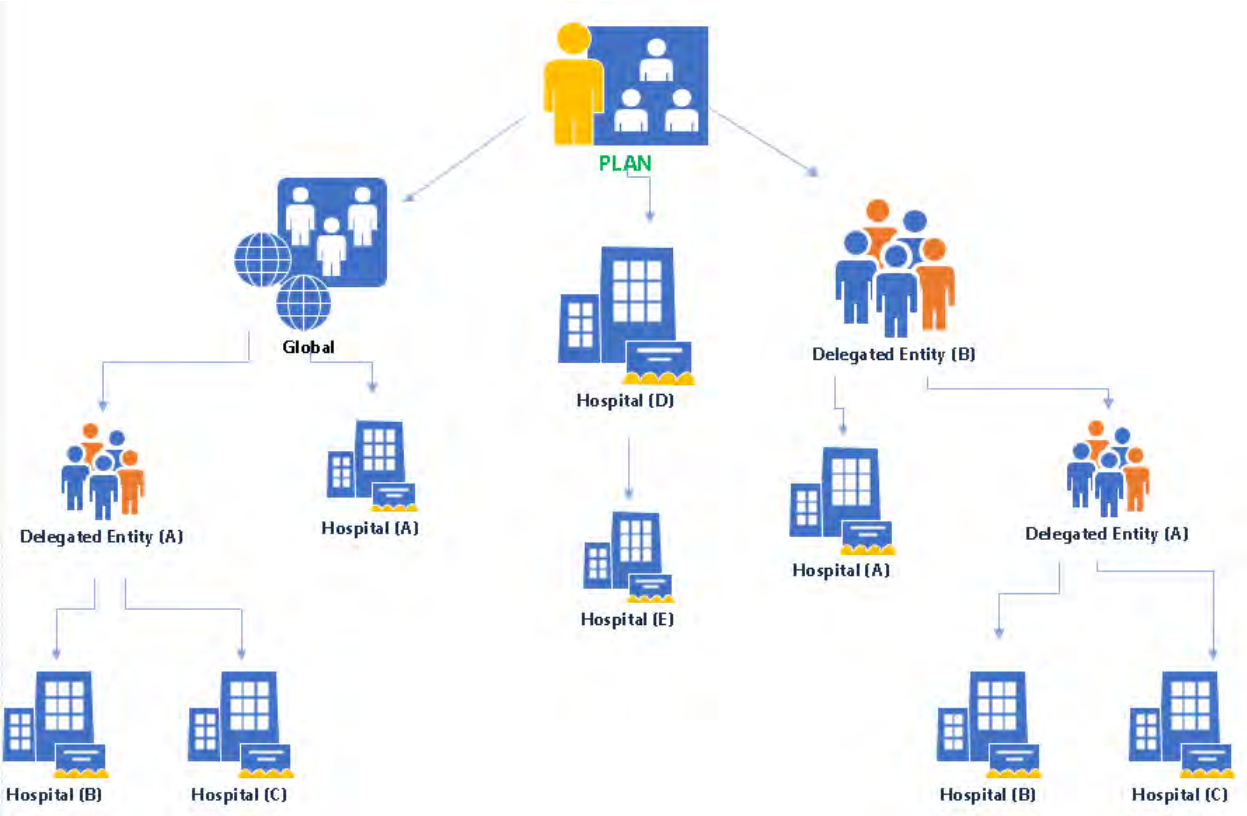
Update 10-19-2018: For purposes of the PHDP, a contract service is a Medi-Cal covered service rendered to a beneficiary actively enrolled in a Plan by an eligible hospital pursuant to a contractual arrangement that meets the minimum criteria outlined in the following notice for the applicable date(s) of service:
https://www.dhcs.ca.gov/services/Documents/DirectedPymts/DHCS_MEMO_Hospital_DP_Definition_20181005.pdf

[3] State-only abortion services are identified by one of the following procedure codes: 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, X7724, X7726, Z0336, 01964, or 01966.

For **SFY 2017-18**, the minimum criteria for an agreement include but are not limited to:

Agreement MUST	Agreement MUST NOT
Cover one or more defined non-excluded populations of Medi-Cal beneficiaries	Be limited to a single patient only
Cover a defined set of one or more non-excluded hospital services	Be limited to treatment of a single case or instance only
Specify rates of payment or include a defined methodology for calculating specific rates of payment	Permit payment to be negotiated on a per patient or single instance of service basis
Be for a set duration of at least 120 days	Expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement

Note: Additional guidance on processes and requirements for reporting contract data to DHCS will be provided at a later date.



Contracting Examples

- ***Example 1:***
  Hospital A has a full-risk capitation agreement with a Plan to care for a specific population. Hospital A also has a contract with Hospital B to provide quaternary care to that population when the service is not available at Hospital A. Hospital B receive payment directly from Hospital A for treating this population.

A) If Hospital B is not contracted with the Plan, are they considered a network provider when providing quaternary services for this population?

Yes, for the specific population and for quaternary services.

B) If Hospital B is contracted with the Plan, but for a different population, are they considered a network provider when providing quaternary services for this population?

Yes, for the specific population and for quaternary services.

- ***Example 2:***
  Hospital A has a contract with an Independent Physicians Association (IPA) to provide ancillary services. If a patient from the IPA presents to the hospital's emergency room and is ultimately admitted as an inpatient for treatment, is Hospital A considered a network provider?

  No for inpatient services; **Yes** for ancillary services.

- ***Example 3:***
  Hospital A has a contract with IPA A to treat their patient population with a Plan. Hospital A does not have a contract with IPA B to treat their population with the Plan. Is Hospital A considered a network provider when they treat members of IPA B?

  No. Hospital A is contracted for IPA A's population only.

Update 10-19-2018:

- ***Example 4***:
  Hospital A has a one-year contract (as defined above) with a Plan to care for a specific population. Hospital A terminates the contract after 90 days. Does this contract meet the requirements under the contracting definition?

  Yes. The term of the agreement was for a period of at least 120 days. However, only services provided during the 90 days under contract would be counted.

PHDP: Implementation Timeline

In order to meet federal timely claim filing deadlines, DHCS must make PHDP payments to Plans no later than September 30, 2019 for Phase I, and no later than March 31, 2020 for Phase II. Therefore, and considering both encounter system lags and the time needed to perform calculations, any additional or revised encounter data must be received by DHCS **no later than December 31, 2018 for Phase I**, and **no later than June 30, 2019 for Phase II**, to be considered during the calculation of final PHDP payments. Encounter data must be submitted through existing, established processes, and DHCS is unable to accept data submitted through a supplemental process.

Note: DHCS anticipates Plans will communicate specific encounter data submission deadlines that are earlier than the due dates noted above. Hospitals and Plans are expected to work together to determine these specific deadlines.

See the graphic below for an overview of the full PHDP implementation timeline.

	ACTIVITY	Q4 CY2018	Q1 CY2019	Q2 CY2019	Q3 CY2019	Q4 CY2019	Q1 CY2020
Phase I	Deadline for Encounter Data Submission to Health Plans	Exact Due Dates are Plan Specific					
	Deadline for Encounter Data Submission to DHCS	December 31, 2018					
	Final Encounter Data Pull for Payment Calculation		March 2019				
	Development of Rate Adjustments			Q2 CY2019			
	Finalization of Rate Adjustments				July 1, 2009		
	Notice of Final Payment Amounts				August 2019		
	Projected Payment to Plans				September 2019		
Phase II	Deadline for Encounter Data Submission to Health Plans			Exact Due Dates are Plan Specific			
	Deadline for Encounter Data Submission to DHCS			June 30, 2019			
	Final Encounter Data Pull for Payment Calculation				September 2019		
	Development of Rate Adjustments					Q4 CY2019	
	Finalization of Rate Adjustments						January 1, 2020
	Notice of Final Payment Amounts						February 2020
	Projected Payment to Plans						March 2020

Note: Additional guidance on processes and requirements for reporting contract data to DHCS will be provided at a later date.

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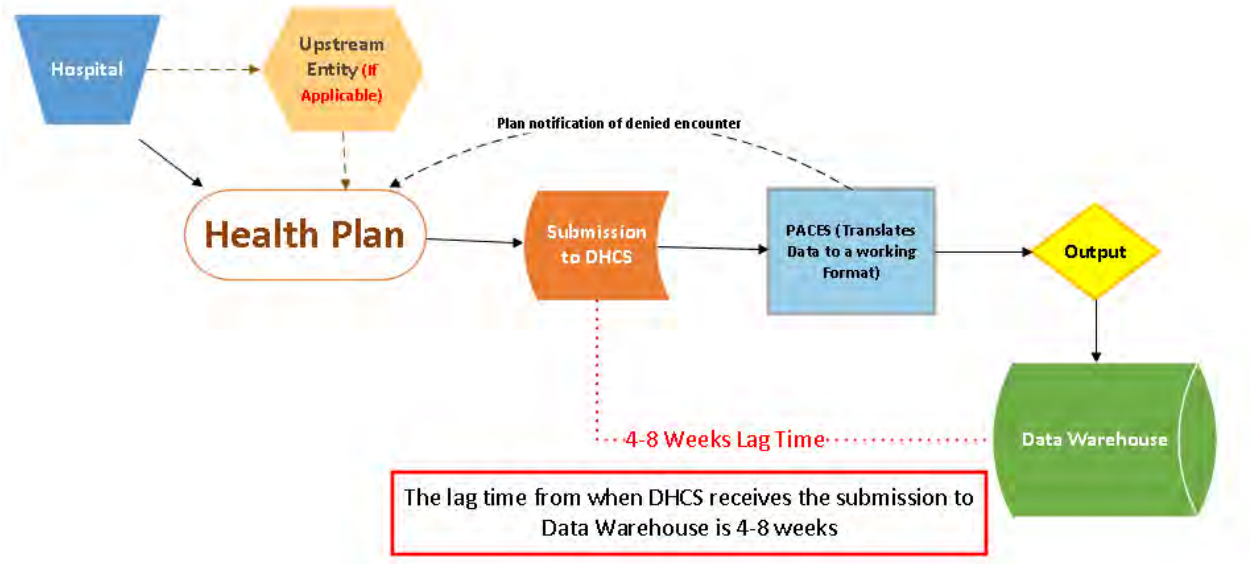
Encounter Data Flow

Encounters are generated by the provider of the service and transmitted, either directly or indirectly through an upstream entity, to the Plan. Once encounters are received, the Plan applies appropriate system edits and submits accepted encounters to DHCS, where the encounter system translates the incoming encounters into a working format that can be queried and used for statistical analysis and reporting. See the chart below for a visual representation of encounter data flow.



There is a 4–8-week lag (approximately) between the time Plans submit encounter data to DHCS and the time DHCS is able to query the encounter data for inclusion in encounter volume charts. As a result, encounter data submitted to DHCS within approximately 8 weeks of the date of the encounter volume chart likely will not be represented.

Update 10-19-2018:
For further background information, please see the Standard Companion Guide Transaction Information released by DHCS, which details how encounter data is transacted once received in DHCS' systems:
https://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Documents/2.02%20834%205010%20Documents/2.02_WEDI_X12_5010_834_CG_TIv3_1v2.pdf

Also, below is a link to DHCS' managed care contract boilerplates:
https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

Counting Logic

Services are counted in accordance with the logic described in Appendix B subject to the caveats indicated below.

Inpatient Hospital days are equal to the Discharge Date (INPAT_DISCHARGE_DT) minus the Service From Date (SVC_FROM_DT). If the two fields contain the same date, the day count is set equal to "1". If INPAT_DISCHARGE_DT is blank, the Service To Date (SVC_TO_DT) is used instead.

For inpatient stays that span the beginning or end of either of the two SFY 2017-18 PHDP phases (July 1, 2017 through December 31, 2017, and January 1, 2018 through June 30, 2018), only the portion of "earned days" occurring during the service period are counted. For example, for Phase I:

Service From Date	Discharge Date	Day Difference	Service Count
07/01/2017	07/01/2017	0	1
07/01/2017	07/02/2017	1	1
07/01/2017	07/03/2017	2	2
06/30/2017	07/01/2017	1	0
06/29/2017	07/02/2017	3	1
12/31/2017	01/01/2018	1	2
12/30/2017	01/02/2018	3	3

For **delivery-related inpatient stays**, the service count is equal to the lesser of:

- The value of the INPAT_DAYS_STAY field; or
- Twice the difference of INPAT_DISCHARGE_DT minus SVC_FROM_DT.
    - If the two fields contain the same date, the day count is set equal to "2".
    - If INPAT_DISCHARGE_DT is blank, SVC_TO_DT is used instead.

Delivery-related inpatient stays are identified as follows:

- PROC_CD is equal to one of the following: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59610, 59612, 59614, 59510, 59514, 59515, 59525, 59618, 59620, 59622
  OR
- REVENUE_CD is equal to one of the following: 720, 721, 722, 724, 729
  OR
- PRIMARY_DIAG_CD_ICD10 is equal to one of the following: 0TQDXZZ, 0DQP0ZZ, 0DQP3ZZ, 0DQP4ZZ, 0DQP7ZZ, 0DQP8ZZ, 0DQR0ZZ, 0DQR3ZZ, 0DQR4ZZ, 0UQG0ZZ, 0UQG3ZZ, 0UQG4ZZ, 0UQG7ZZ, 0UQG8ZZ, 0UQGXZZ, 0UQM0ZZ, 0UQMXZZ, 0WQNXZZ, 0UJD7ZZ, 0W3R0ZZ, 0W3R3ZZ, 0W3R4ZZ, 0W3R7ZZ, 0W3R8ZZ, 2Y44X5Z, 0JCB0ZZ, 0JCB3ZZ, 0UCG0ZZ, 0UCG3ZZ, 0UCG4ZZ, 0UCM0ZZ, 0US90ZZ, 0US94ZZ, 0US9XZZ, 10H003Z, 10H00YZ, 10P003Z, 10P00YZ, 10P073Z, 10P07YZ, O6010X0, O6010X1, O6010X2, O6010X3, O6010X4, O6010X5, O6010X9, O6012X0, O6012X1, O6012X2, O6012X3, O6012X4, O6012X5, O6012X9, O6013X0, O6013X1, O6013X2, O6013X3, O6013X4, O6013X5, O6013X9, O6014X0, O6014X1, O6014X2, O6014X3, O6014X4, O6014X5, O6014X9, O6020X0, O6020X1, O6020X2, O6020X3, O6020X4, O6020X5, O6020X9, O6022X0, O6022X1, O6022X2, O6022X3, O6022X4, O6022X5, O6022X9, O6023X0, O6023X1, O6023X2, O6023X3, O6023X4, O6023X5, O6023X9, O670, O678, O679, O68, O690XX0, O690XX1, O690XX2, O690XX3, O690XX4, O690XX5, O690XX9, O691XX0, O691XX1, O691XX2, O691XX3, O691XX4, O691XX5, O691XX9, O692XX0, O692XX1, O692XX2, O692XX3, O692XX4, O692XX5, O692XX9, O693XX0, O693XX1, O693XX2, O693XX3, O693XX4, O693XX5, O693XX9, O694XX0, O694XX1, O694XX2, O694XX3, O694XX4, O694XX5, O694XX9, O695XX0, O695XX1, O695XX2, O695XX3, O695XX4, O695XX5, O695XX9, O6981X0, O6981X1, O6981X2, O6981X3, O6981X4, O6981X5, O6981X9, O6982X0, O6982X1, O6982X2, O6982X3, O6982X4, O6982X5, O6982X9, O6989X0, O6989X1, O6989X2, O6989X3, O6989X4, O6989X5, O6989X9, O699XX0, O699XX1, O699XX2, O699XX3, O699XX4, O699XX5, O699XX9, O700, O701, O702, O703, O704, O709, O720, O721, O722, O723, O730, O731, O740, O741, O742, O743, O744, O745, O746, O747, O748, O749, O750, O751, O752, O753, O754, O755, O7581, O7582, O7589, O759, O76, O770, O771, O778, O779, O778, O779

For non-Inpatient visits, a visit is counted for each unique combination of patient (AKA_CIN), provider (NPI), and date of service (Service From Date).

- For ER services, the header-level date of service on the encounter record is used.
- For OP services, the detail-level date of service on the encounter record is used. This is intended to account for recurring visits where multiple visits are reported on one claim or encounter, such as for a series of physical therapy visits.

Questions

For questions, please contact:

- Private Hospitals – PrivateDP@dhcs.ca.gov
- Plans – PlanDP@dhcs.ca.gov

This toolkit and the statewide directory of private hospital and Plan contacts will be posted on DHCS's public website in the near future. Links will be provided at a later date.

Appendix A: Encounter Volume Chart Release Schedule

Volume Chart Release Date	NPI Cutoff Date	Encounter Data Received by DHCS as of … (est.)	Data for:
June 29, 2018	N/A	March-April 2018	July 1, 2017 – December 31, 2017
August 17, 2018	July 27, 2018	May 2018	July 1, 2017 – February 28, 2018
October 12, 2018	September 28, 2018	Early August 2018	July 1, 2017 – April 30, 2018
November 9, 2018	October 26, 2018	Early September 2018	July 1, 2017 – June 30, 2018

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Appendix B: Volume Chart Data Elements

Update 10-19-2018:

Note: The following fields were populated with an "X" if they were left blank in the Summary Files.

OC_CD
CLAIM FORM IND
FI_CLAIM_TYPE_CD
FI_PROV_TYPE_CD
PROV SPEC CD
PROV_TAXON
POS_CD
REVENUE_CD
VENDOR_CD

Update 10-19-2018: Organized data elements alphabetically and added new elements and descriptions as appropriate.

ADJ_IND -

Code	Description
	Not an adjustment
1	Positive Supplemental
2	Negative Supplemental (negative only)
3	Refund to Medi-Cal (negative only)
4	Positive side of void and reissue
5	Negative side of void and reissue
6	Cash disposition (obsolete)

ADMIT_FAC_NPI - Admitting Facility NPI (from Claims)

AGE - Age of Beneficiary

AKA_CIN - Actual non-masked CIN Number

BENE_FIRST_NAME - Beneficiary First Name

BENE_LAST_NAME - Beneficiary Last Name

BENE_BIRTH_DT - Beneficiary Birth Date

BILL_TYPE_CD - A four-digit numeric code which identifies the specific type of bill (inpatient, outpatient, adjustments, voids, etc.). The first digit represents Type of Facility, the second digit the Bill Classification, and the third digit the Frequency. The first and second positions are separated from the third by the qualifier.

BIRTH_DT - Birth Date

CCN - CMS' Certification Number (CCN), is the hospital's identification number and is linked to its Medicare provider agreement.

CHECK_DT - Check Issue Date

CLAIM_FORM_IND - Identifies if the claim form used is a UB-92 or a HCFA-1500 form

CLINIC_TYPE - Generated field based on a specified list of NPIs

FQ – Federally Qualified Health Centers
RH – Rural Health Clinic
IH – Indian Health Service
CB – Cost Based Reimbursement Clinics
NA – None of the Above

DTL_SVC_FROM_DT - Detail Service From Date

DTL_SVC_TO_DT - Detail Service To Date

ENCRYPTED_AKA_CIN - Encrypted CIN

FI_CLAIM_TYPE_CD -

Code	Description
	Unknown
01	Pharmacy
02	Long Term Care
03	Hospital Inpatient
04	Outpatient
05	Medical/Allied
06	Code not used at DHCS
07	Vision
09	Code not used at DHCS
5	Unknown
55	Unknown
AP	Advanced Payment (No Provider) (IHSS)
CC	Contract County Provider (IHSS)
IP	Individual Provider (IHSS)
RM	Restaurant & Meals (No Provider) (IHSS)

FI_PROV_TYPE_CD -

Code	Description
	UNKNOWN
000	UNKNOWN
001	ADULT DAY HEALTH CARE CENTERS
002	ASSISTIVE DEVICE AND SICK ROOM SUPPLY DEALERS
003	AUDIOLOGISTS

004	BLOOD BANKS
005	CERTIFIED NURSE MIDWIFE
006	CHIROPRACTORS
007	CERTIFIED NURSE PRACTIONER
008	CHRISTIAN SCIENCE PRACTIONER
009	CLINICAL LABORATORIES
010	GROUP CERTIFIED NURSE PRACTITIONER
011	FABRICATING OPTICAL LABORATORY
012	DISPENSING OPTICIANS
013	HEARING AID DISPENSERS
014	HOME HEALTH AGENCIES
015	COMMUNITY OUTPATIENT HOSPITAL
016	COMMUNITY INPATIENT HOSPITAL
017	LONG TERM CARE FACILITY
018	NURSE ANESTHETISTS
019	OCCUPATIONAL THERAPISTS
020	OPTOMETRISTS
021	ORTHOTISTS
022	PHYSICIANS GROUP
023	GROUP OPTOMETRISTS
024	PHARMACIES/PHARMACISTS
025	PHYSICAL THERAPISTS
026	PHYSICIANS
027	PODIATRISTS
028	PORTABLE X-RAY
029	PROSTHETISTS
030	GROUND MEDICAL TRANSPORTATION
031	PSYCHOLOGISTS
032	CERTIFIED ACUPUNTURIST
033	GENETIC DISEASE TESTING
034	MEDICARE CROSSOVER PROVIDER ONLY
035	RURAL HEALTH CLINICS/FEDERALLY QUALIFIED HEALTH CENTER
036	UNKNOWN
037	SPEECH THERAPISTS
038	AIR AMBULANCE TRANSPORTATION SERVICES
039	CERTIFIED HOSPICE
040	FREE CLINIC
041	COMMUNITY CLINIC
042	CHRONIC DIALYSIS CLINIC
043	MULTISPECIALTY CLINIC
044	SURGICAL CLINIC
045	CLINIC EXEMP FROM LICENSURE
046	REHABILITATION CLINIC

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047	UNKNOWN
048	COUNTY CLINICS NOT ASSOCIATED WITH HOSPITAL
049	BIRTHING CENTER SERVICES
050	OTHERWISE UNDESIGNATED CLINIC
051	OUTPATIENT HEROIN DETOX CENTER
052	ALTERNATIVE BIRTH CENTERS - SPECIALTY CLINIC
053	EVERY WOMAN COUNTS
054	EXPANDED ACCESS TO PRIMARY CARE
055	LOCAL EDUCATION AGENCY
056	RESPIRATORY CARE PRACTITIONER
057	EPSDT SUPPLEMENTAL SERVICES PROVIDER
058	HEALTH ACCESS PROGRAM
059	HOME AND COMMUNITY BASED SERVICES NURSING FACILITY
060	COUNTY HOSPITAL INPATIENT
061	COUNTY HOSPITAL OUTPATIENT
062	GROUP RESPIRATORY CARE PRACTITIONERS
063	LICENCED BUILDING CONTRACTORS
064	EMPLOYMENT AGENCY
065	PEDIATRIC SUBACUTE CARE/LTC
066	PERSONAL CARE AGENCY
067	RVNS INDIVIDUAL NURSE PROVIDERS
068	HCBC BENEFIT PROVIDER
069	PROFESSIONAL CORPORATION
070	LICENSED CLINICAL SOCIAL WORKER INDIVIDUAL
071	LICENSED CLINICAL SOCIAL WORKER GROUP
072	MENTAL HEALTH INPATIENT SERVICES
073	AIDS WAIVER SERVICES
074	MULTIPURPOSE SENIOR SERVICES PROGRAM
075	INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT
076	DRUG MEDI-CAL
077	MARRIAGE AND FAMILY THERAPIST INDIVIDUAL
078	MARRIAGE AND FAMILY THERAPIST GROUP
080	CCS/GHPP NON-INSTITUTIONAL
081	CCS/GHPP INSTITUTIONAL
082	LICENSED MIDWIVES
084	INDEPENDENT DIAGNOSTIC TESTING FACILITY XOVER PROV ONLY
085	CLINICAL NURSE SPECIALIST X-OVER PROVIDER ONLY
086	MEDICAL DIRECTORS
087	LICENSED PROFESSIONALS
089	ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM
090	OUT OF STATE
092	RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)
093	CARE COORDINATOR (CCA).

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095	PRIVATE NON-PROFIT PROPRIETARY AGENCY
098	UNKNOWN
099	UNKNOWN

HOSPITAL_NAME - Name of Hospital

HOSPITAL_SYSTEM - The names of the Hospitals derived based on NPIs

INPAT_ADMISSION_DT - Admission Date identifies the date the patient was admitted to the hospital (Inpatient and LTC claims only).

INPAT_DAYS_STAY - Inpatient Days Stay is only populated for inpatient and Long Term Care claims.

INPAT_DISCHARGE_DT - Discharge Date identifies the date the patient was discharged (Inpatient and LTC claims only).

INPAT_DISCHARGE_DT_FLAG - If =1, the blank INPAT_DISCHARGE_DT was populated with SVC_TO_DT

MAIN_SGMNT_ID_NO - Claim Line Number

MC_HDR_MEDI_CAL_PAID_AMT - Header Paid Amount

MC_STAT_A OR MC_STAT_B -

Code	Description
	No coverage
0	No coverage
1	Paid for by beneficiary
2	Paid for by State Buy-In
3	Free (Part A only)
4	Paid by state other than California
5	Paid for by Pension Fund
6	UNKNOWN
7	Presumed eligible
8	UNKNOWN
9	Aged alien ineligible for Medicare

Full Duals must meet both criteria:

- Medicare Indicator A – 1, 2, 3, 4, or 5
- Medicare Indicator B – 1, 2, 4 or 5

MC_STAT_D - Indicates an enrollee's Medicare Part D status

MEDICARE_STATUS -

Full Dual – Both Medicare Part A and Part B
MC_Part_A – Medicare Part A

MC Part B – Medicare Part B
MCal_only – No Medicare

MEDI_CAL_REIMB_AMT - Detail Paid Amount

NPI - National Provider Number (from Claims Header)

OC_CD - Identifies the Other Health Coverage (OC) circumstances for each service rendered

Value	Description
	No Coverage
2	Provident Life and Accident (no longer in use)
3	Principal Financial Group (no longer in use)
4	Pacific Mutual Life Insurance (no longer in use)
6	AARP (no longer in use)
9	Healthy Families
A	Any Carrier (includes multiple coverage), pay and chase
B	Blue Cross (no longer in use)
C	CHAMPUS Prime HMO
D	Medicare Part D
E	Plans Limited to Vision Coverage
F	Medicare Risk HMO (formerly First Farwest)
G	CDCR Medical Parolee Plan (formerly American General)
H	Multiple Plans Comprehensive
I	Public Institution Coverage (formerly Metropolitan Life)
K	Kaiser
L	Dental only policies
M	Two or more carriers (no longer in use)
N	No Coverage
O	Override - Used to remove cost avoidance OHC codes posted by DHS Recovery or data matches (OHC Source is H, R, or T). Changes OHC to A.
P	PHP/HMOs and EPO (Exclusive Provider Option) not otherwise specified
Q	Pharmacy Plans Only(Non-Medicare)
R	Ross Loos (no longer in use)
S	Blue Shield (no longer in use)
T	Travelers (no longer in use)
U	Connecticut General (no longer in use)
V	Any carrier other than above, includes multiple coverage (formerly Variable)
W	Multiple Plans Non-Comprehensive
X	Blue Shield (no longer in use)
Y	Blue Cross North (no longer in use)
Z	Blue Cross South (no longer in use)

PAT_CTL_NBR – Patient Control Number. Identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment.

PLAN_CD - Plan Code from Eligibility Table

PLAN_CAP_AID_CD - Aid Codes based on capitation payments

PLAN_NAME - Health Plan Name

POS_CD - Point of Service Code

POS_CD	***Description***
0	Emergency Room
1	Inpatient Hospital
2	Outpatient Hospital
3	Nursing Facility, Level A/B
4	Home
5	Office, Lab, Clinic
6	ICF-DD
7	Other

PRIMARY_DIAG_CD - Primary Diagnosis Code

PRIMARY_DIAG_CD_ICD10 - Primary Diagnosis Coded for ICD-10.

PROC_CD - Procedure Code

PROC_IND -

Code	Description
	EDS Inpatient long-term care (LTC) Note: the procedure code field is a space, so the accommodation code is used.
0	DELTA Dental Table of Dental Procedures (prior to 7/1/93 when HCPCS [Health Care Financing Administration Common Procedure coding system] replaced them)
1	UB-92s ([Uniform Billing - 1992] Uniform Billing codes began on January 1, 1992.)
2	SMA [Scheduled Maximum Allowance] (replaced by HCPCS Levels II and III except for special rural health clinic/federally qualified health center codes) Note: EPSDT (Early Periodic Screening, Diagnosis and Treatment) claims always use this indicator.
3	UPC (Universal Product Code), PIN (Product Identification Number), HRI (Health Related Item), NDC (National Drug Code) codes for drugs, NDC medical supply codes and state drug code IDs for Medical Supplies. SEE F35B-MEDICAL-SUPPLY-INDICATOR and F35B-PROCE
4	CPT-4 (as of 11/1/87 -- Current Procedure Terms: A systematic listing and coding of healthcare procedures and services performed by clinicians. The American Medical Associations CPT-4 refers to procedures delivered by physicians.)
5	Unknown
6	California Health Facilities Commission (CHFC)
7	Los Angeles Waiver/L. A. Waiver
8	Short-Doyle/Medi-Cal (only on Plan Code 8)
9	HCPCS Levels II and III (effective on October 1, 1992)

PROV_SPEC_CD – Provider Specific Code

Code	Description
	Unknown
	Unknown
0	Unknown
1	Unknown
2	Unknown
3	Unknown
4	Unknown
5	Unknown
6	Unknown
7	Unknown
8	Unknown
#N	Unknown
*G	Unknown
*N	Unknown
00	General Practioner (Dentists Only)
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease (M.D. only)
07	Dermatology
08	Family Practice
09	Gynecology (D.O. only)
0X	UNKNOWN
1	Unknown
10	Gastroenterology (M.D. only), Oral Surgeon (Dentists Only)
11	Aviation (M.D. only)
12	Manipulative Therapy (D.O. only)
13	Neurology (M.D. only)
14	Neurological Surgery
15	Obstetrics (D.O. only), Endodontist (Dentists Only)
16	Obstetrics-Gynecology (M.D. Only) Neonatal
17	Ophthalmology, Otolaryngology, Rhinology (D.O. only)
18	Ophthalmology
19	Dentists (DMD)
1A	Unknown
1B	Unknown
1C	Unknown
1G	Unknown

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1Y	Unknown
2	Nurse Practitioner (non-physician medical practitioner)
20	Orthopedic Surgery, Orthodontist (Dentists Only)
21	Pathologic Anatomy: Clinical Pathology (D.O. only)
22	Pathology (M.D. only)
23	Peripheral Vascular Disease or Surgery (D.O. only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation, Certified Orthodontist (Dentists Only)
26	Psychiatry (child)
27	Psychiatry Neurology (D.O. only)
28	Proctology (colon and rectal)
29	Pulmonary Diseases (M.D. only)
2X	Unknown
3	Physician Assistant (non-physician medical practitioner)
30	Radiology, Pedodontist (Dentists Only)
31	Roentgenology, Radiology (M.D. only)
32	Radiation Therapy (D.O. only)
33	Thoracic Surgery
34	Urology and Urological Surgery
35	Pediatric Cardiology (M.D. only)
36	Psychiatry
37	Unknown
38	Geriatrics
39	Preventive (M.D. only)
4	Nurse Midwife (non-physician medical practitioner)
40	Pediatrics, Periodontist (Dentists Only)
41	Internal Medicine
42	Nuclear Medicine
43	Pediatric Allergy
44	Public Health
45	Nephrology (Renal-Kidney)
46	Hand Surgery
47	Miscellaneous
48	Unknown
49	Unknown
5	Unknown
50	Prosthodontist (Dentists Only)
51	Unknown
52	Unknown
53	Unknown
54	Unknown
55	Unknown
56	Unknown

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57	Unknown
58	Unknown
59	Unknown
6	Unknown
60	Oral Pathologist (Dentists Only)
61	Unknown
62	Unknown
63	Unknown
64	Unknown
65	Unknown
66	Emergency Medicine (Urgent Care)
67	Endocrinology
68	Hematology
69	Unknown
6Y	Unknown
7	Unknown
70	Clinic (mixed specialty), Public Health (Dentists Only)
71	Unknown
72	Unknown
73	Unknown
74	Unknown
75	Unknown
76	Unknown
77	Infectious Disease
78	Neoplastic Diseases/Oncology
79	Neurology-Child
7A	Unknown
8	Unknown
80	Full-Time Facility (Dentists Only)
81	Unknown
82	Unknown
83	Rheumatology
84	Surgery-Head and Neck
85	Surgery-Pediatric
86	Unknown
87	Unknown
88	Unknown
89	Surgery-Traumatic
9	Unknown
90	Pathology-Forensic
91	Pharmacology-Clinical
92	Unknown
93	Marriage, family and child counselor

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94	Licensed clinical social worker
95	Registered nurse
96	Unknown
97	Unknown
98	Unknown
99	Unknown (on EDS claims)

PROV_TAXON - Billing Provider taxonomy identifies the provider type, classification, and specialization for the billing provider (Claims Header Information).

RECORD_ID - Record Identification Number provides a unique number for each claim header record.

- **Update 10-19-2018:** The first four digits of RECORD_ID indicate the year and month the Plan submitted the encounter record to DHCS. For example, if a Plan submitted the encounter record on August 19, 2018, the first four digits would be listed as 1808.

REF_PRESC_NPI - Referring Prescribing NPI (from Claims Detail)

REMOVE_NOTE - The reason a service count was removed i.e. (Full Duals, Part A or B, Other Coverage, NA)

REMOVE_SVC_CNT - A DHCS derived field that indicates how many units of service have been subtracted. This subtraction removes services performed at a CBRC, FQHC, IHCP, or RHC. It also removes services provided to enrollees with other health coverage as well as inpatient services provided to enrollees with Medicare Part A, and Non-Inpatient services provided to enrollees with Medicare Part B.

REND_OPERATING_NPI - Rendering Operating NPI (from Claims Detail)

REVENUE_CD - Revenue Code

SEC_DIAG_CD - Secondary Diagnosis Code

SEC_DIAG_CD_ICD10 - Secondary Diagnosis Code for ICD-10 identifies a patient's secondary diagnosis, which requires supplementary medical treatment.

SVC_CAT - Category of Service (COS) groups

SVC_CAT	Description
S01_IP	Inpatient Hospital
S02_ER	Emergency Room
S03_OP	Outpatient Facility
S04_LTC	Long-Term Care
S05_SP	Physician Specialty
S06_PCP	Physician Primary Care
S07_MHOP	Mental Health - Outpatient
S08_NPP	Other Medical Professional
S09_FQHC	FQHC
S10_OTH	All Other

COS is based on the COS grouping logic and hierarchy. For example, inpatient (S01) has a higher hierarchy than outpatient (S02). If a record meets both the criteria for inpatient and outpatient, that record will be classified as inpatient. See Appendix C for more details.

SVC_CNT - Service unit count (see Appendix C)

SVC_FROM_DT - Header Service From Date

SVC_TO_DT - Header Service To Date

SVC_UNITS_NBR - Service Units

VENDOR_CD -

Code	Description
	Unknown
M	INVALID
0	Unknown
00	INVALID
01	Adult Day Health Care Centers
02	Medicare Crossover Provider Only
03	CCS / GHPP
04	Genetic Disease Testing
05	Certified Nurse Midwife
06	Certified Hospice Service
07	Certified Pediatric NP
08	Certified Family NP
09	Respiratory Care Practitioner
1	UNKNOWN
10	Licensed Midwife Program
11	Fabricating Optical Labs
12	Optometric Group
13	Nurse Anesthetist
14	Expanded Access to Primary Care
16	INVALID
19	Portable X-ray Lab
2	INVALID
20	Physicians (MD or DO)
21	Ophthalmologist (San Joaquin Foundation only)
22	Physicians Group
23	Lay Owned Lab Services(RHF)
24	Clinical Lab
25	INVALID
26	Pharmacies
27	Dentist

28	Optometrist
29	Dispensing Optician
30	Chiropractor
31	Psychologist
32	Podiatrist
33	Acupuncturist
34	Physical Therapist
35	Occupational Therapist
36	Speech Therapist
37	Audiologist
38	Prosthetist
39	Orthotist
40	Other Provider (non-prof. prov svcs)
41	Blood Bank
42	Medically Required Trans
44	Home Health Agency
45	Hearing Aid Dispenser
47	Intermediate Care Facility-Developmentally Disabled
49	Birthing Center
5	INVALID
50	County Hosp - Acute Inpatient
51	County Hosp - Extended Care
52	County Hosp - Outpatient
53	Breast Cancer Early Detection Program
55	Local Education Agency
56	State Developmental Centers
57	State Hosp - Mentally Disabled
58	County Hosp - Hemodialysis Center
59	County Hosp - Rehab Facility
6	UNKNOWN
60	Comm Hosp - Acute Inpatient
61	Comm Hosp - Extended Care
62	Comm Hosp - Outpatient
63	Mental Health Inpatient Consolidation
64	Short Doyle Comm MH - Hosp Svcs
68	Comm Hosp - Renal Dialysis Center
69	Comm Hosp - Rehab Facility
70	Acute Psychiatric Hosp
71	Home/Comm Based Service Waivers
72	Surgicenter
73	AIDS Waiver Services
74	Short Doyle Comm MH Clinic Svcs
75	Organized Outpatient Clinic

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76	DDS Waiver Services
77	Rural Health Clinics/FQHCs/Indian Health Clinics
78	Comm Hemodialysis Center
79	Independent Rehabilitation Facility
8	Unknown
80	Nursing Facility (SNF)
81	MSSP Waiver Services
82	EPSDT Supplemental Services
83	Pediatric Subacute Rehab/Weaning
84	Assist. Living Waiver Pilot Project (ALWPP)
87	INVALID
88	Self-Directed Services(SDS) Waiver Services
89	Personal Care Services Program (IHSS)
9	Unknown
90	Others and Out-of-State
91	Outpat Heroin Detox
92	Medi-Cal Targeted Case Management
93	DDS Targeted Case Management
94	CHDP Provider
95	Short Doyle Comm MH - Rehab Treatment
99	INVALID
A1	INVALID
B1	INVALID
CQ	Unknown
DN	Unknown
NF	Unknown
OD	INVALID
OE	INVALID
OG	INVALID
OH	INVALID
OL	INVALID
OM	INVALID
OO	INVALID
OS	INVALID
OT	INVALID
PA	Unknown
PC	Unknown
PS	Unknown
XX	INVALID

Appendix C: Category of Service Groupings - Mapping Logic

Notes for COS Mapping Logic:

1. DHCS groups data into different Categories of Service (COS). Below is a description of the hierarchy used to identify each of the COS.
2. Logic Format Notes: 1) All bullet points under each criteria must be met to satisfy that criteria. 2) For COS where there are multiple criteria, there is a line hat reads: "Criteria Combinations". This line explains which criteria need to be met in order to satisfy the requirement for assignment to the COS. For example, if the line reads "Criteria Combinations - (1,2) or (1,3) or (1,4)", then if criteria 1 AND 2, or 1 AND 3, or 1 AND 4 are met, then the claim should be assigned to the COS.
3. The categories of service are listed in hierarchical order and should be followed when claims meet criteria for more han one COS. For example, if a claim meets criteria for both Inpa ient and Emergency Room, the claim would be assigned to Inpatient because Inpatient is listed higher on the hierarchy than Emergency Room.
4. Any one claim/encounter is classified into only one COS. Therefore, if a claim has multiple detail lines with varying COS assignments, use the hierarchy to decide the COS to which the entire claim will be assigned.
5. Crossover claims should be reported in their corresponding COS.

Inpatient Hospital

Unit Type	Unit type special instructions
Days	One inpatient stay per calendar day per member for "earned days" occuring during the service period (Day Count is equal to INPAT_DISCHARGE_DT minus SVC_FROM_DT; when SVC_FROM_DT = INPAT_DISCHARGE_DT, then Day Count = 1)

Description: Facility-related expenses for hospital inpatient services, including room, board, and ancillary charges.
- **Includes** any Emergency Room facility charges for individuals who are admitted to the hospital on an inpatient basis.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).
- **Excludes** outpatient and Emergency Room (that does not result in an inpatient admission)
- **Excludes** LTC

Criteria #1
- **CLAIM FORM IND** = "U"
- **FI CLAIM TYPE CD** = "03" (Inpatient Hospital)

Criteria #2
- **INPAT DISCHARGE DT** or **SVC TO DT** > **SVC FROM DT**

Criteria #3
- **Provider Type Codes**

60 - County Hospital Inpatient	72 - Mental Health Inpatient
16 - Community Hospital Inpatient	

Criteria #4
- **INPAT DAYS STAY** ≥ 1

Criteria Combinations - (1,2) or (1,3) or (1,4)

Community-Based Adult Services (CBAS)

Unit Type	Unit type special instructions
Days	Do not count more than one day as a unit per calendar day per member

Description: All expenses related to services provided by a CBAS center. CBAS replaced the former Adult Day Health Care program effective April 1, 2012.
- **Includes** both the per day CBAS costs as well as CBAS assessment costs.
- **Excludes** LTC facility costs as they are reported in the LTC facility COS line.

Criteria #1

Vendor Codes
01 - Adult Day Health Care Centers

Criteria #2

Procedure Codes	
H2000 - Comp multidisipln evaluation	S5102 - Adult day care per diem
T1023 - Program intake assessment	S5100 - day care services, adult per 15 minutes
S5101 - day care services, adult per half day	

Criteria Combinations - (1) or (2)

Emergency Room

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and facility (NPI)

Description: All facility-related expenses of an Emergency Room visit that did not result in an inpatient admission.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).
- After applying all COS logic, look for any OP facility claims occurring on the same day a member had an ER professional claim and reclassify these from OP Facility COS to ER COS

Criteria #1
- Claims with **FI CLAIM TYPE CD** = 04 (Outpatient)

Criteria #2
- **POS CD** = 0 (Emergency Room)

Criteria #3
- PROC_CD of Z7502, 99281, 99282, 99283, 99284, or 99285

Criteria #4
- Revenue Code of 450, 451, 452, 453, 454, 455, 456, 457, 458, or 459

Criteria Combinations - (1,2) or (1,3) or (1,4)

Outpatient Facility

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (DTL_SVC_FROM_DT), and provider (NPI)

Description: All facility-related expenses incurred for outpatient services.
- **Excludes** Emergency Room
- **Includes** all facility-related costs for non-inpatient services from a hospital or other outpatient facilities such as an ambulatory surgery center.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).

Criteria #1
- **Provider Type Codes**

61 - County Hospital Outpatient	15 - Community Hospital Outpatient Departments
49 - Birthing Centers-Primary Care Clinics	52 - Alternative Birth Centers- Specialty Clinics
44 - Surgical Clinics	42 - Chronic Dialysis Clinics

Criteria #2
- **FI CLAIM TYPE CD** = 04 (Outpatient)
- **Provider Type Codes**

60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

Criteria #3
- **FI CLAIM TYPE CD** = 02 (Long Term Care) or 03 (Hospital Inpatient)
- **POS CD** = 2 (Outpatient Hospital) or 5 (Office, Lab, Clinic)

Criteria #4
- **FI PROV TYPE CD** = 50 (Clinic-otherwise undesignated)
- **Provider Taxonomy Codes**

261QX0200X	261QP3300X

Criteria Combinations - (1) or (2) or (3) or (4)

Other

Unit Type	Unit type special instructions
Varies	Varies

Description: All other MCO-covered medical services not grouped in another category of service, such as Behavioral Health Treatment, Mental Health - Outpatient, Long-Term Care, Federally Qualified Health Center, Specialty Physician, Primary Care Physician, Other Medical Professional, Hospice, Multipurpose Senior Services Program, In-Home Supportive Services, Home and Community Based Services Other, Lab and Radiology, Pharmacy, Transportation, and All Other.

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Appendix D: Crosswalk of Plan Names to Health Care Plan Codes

Plan Name	County	Plan Code	Region
Aetna	Sacramento	15	GMC
	San Diego	16	GMC
United	Sacramento	17	GMC
	San Diego	18	GMC
Alameda Alliance for Health	Alameda	300	Two-Plan
Anthem	Alpine	100	Regional
	Amador	101	Regional
	Butte	102	Regional
	Calaveras	103	Regional
	Colusa	104	Regional
	El Dorado	105	Regional
	Glenn	106	Regional
	Inyo	107	Regional
	Mariposa	108	Regional
	Mono	109	Regional
	Nevada	110	Regional
	Placer	111	Regional
	Plumas	112	Regional
	Sierra	113	Regional
	Sutter	114	Regional
	Tehama	115	Regional
	Tuolumne	116	Regional
	Yuba	117	Regional
	Fresno	362	Two-Plan
	Tulare	311	Two-Plan
	Alameda	340	Two-Plan
	San Francisco	343	Two-Plan
	Contra Costa	344	Two-Plan
	Kings	363	Two-Plan
	Madera	364	Two-Plan
	San Benito	144	Regional
	Sacramento	190	GMC
	Santa Clara	345	Two-Plan
CalOptima	Orange	506	COHS
CalViva Health	Fresno	315	Two-Plan
	Kings	316	Two-Plan
	Madera	317	Two-Plan

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Plan Name	County	Plan Code	Region
CA Health & Wellness	Imperial	143	Regional
	Tehama	139	Regional
	Tuolumne	141	Regional
	Alpine	118	Regional
	Amador	119	Regional
	Butte	120	Regional
	Calaveras	121	Regional
	Colusa	122	Regional
	El Dorado	123	Regional
	Glenn	124	Regional
	Inyo	128	Regional
	Mariposa	129	Regional
	Mono	133	Regional
	Nevada	134	Regional
	Placer	135	Regional
	Plumas	136	Regional
	Sierra	137	Regional
	Sutter	138	Regional
	Yuba	142	Regional
Care 1st	San Diego	167	GMC
CenCal	San Luis Obispo	501	COHS
	Santa Barbara	502	COHS
Central CA Alliance for Health	Merced	514	COHS
	Santa Cruz	505	COHS
	Monterey	508	COHS
Community Health Group	San Diego	29	GMC
Contra Costa HP	Contra Costa	301	Two-Plan
Gold Coast HP	Ventura	515	COHS
Health Net	Los Angeles	352	Two-Plan
	Tulare	353	Two-Plan
	San Joaquin	354	Two-Plan
	Kern	360	Two-Plan
	Sacramento	150	GMC
	San Diego	68	GMC
	Stanislaus	361	Two-Plan

Plan Name	County	Plan Code	Region
HP of San Joaquin	San Joaquin	308	Two-Plan
	Stanislaus	312	Two-Plan
HP of San Mateo	San Mateo	503	COHS
Inland Empire HP	Riverside	305	Two-Plan
	San Bernardino	306	Two-Plan
Kaiser	Sacramento	170	GMC
	San Diego	79	GMC
	Amador	177	Regional
	Placer	179	Regional
	El Dorado	178	Regional
Kern Health Systems	Kern	303	Two-Plan
LA Care HP	Los Angeles	304	Two-Plan
Molina	Sacramento	130	GMC
	Imperial	145	Regional
	San Diego	131	GMC
	Riverside	355	Two-Plan
	San Bernardino	356	Two-Plan
Partnership Health Plan	Marin	510	COHS
	Napa	507	COHS
	Solano	504	COHS
	Yolo	509	COHS
	Sonoma	513	COHS
	Mendocino	512	COHS
	Lake	511	COHS
	Humboldt	517	COHS
	Lassen	518	COHS
	Modoc	519	COHS
	Shasta	520	COHS
	Siskiyou	521	COHS
	Trinity	522	COHS
	Del Norte	523	COHS
San Francisco Health Plan	San Francisco	307	Two-Plan
Santa Clara Family HP	Santa Clara	309	Two-Plan

Appendix E: Change Log

Changes from Previous Versions			
ID	**Change Description**	**Toolkit Section**	**Version Date**
1	Updated SFTP access link	Volume Charts	08/2018
2	Added encounter volume chart release details	Volume Charts	08/2018
3	Added phased implementation	PHDP: Structure and Policy	08/2018
4	Added NPI & LTC update	Exclusions	08/2018
5	Updated implementation schedule	PHDP: Implementation Timeline	08/2018
6	Updated data release schedule	Appendix A	08/2018
7	Added more fields and descriptions	Appendix B	08/2018
8	Added Appendix E: Change Log	Appendix E	08/2018
9	Added Appendix F: Sample Encounter Volume Chart	Appendix F	08/2018
10	Identified State-only abortion services as an excluded service category	Exclusions	10/2018
11	Added new contracting service definition guidance	Contract Services	10/2018
12	Added links to Companion Guide and Managed Care contract boilerplates	Encounter Data	10/2018
13	Added new Counting Logic section	Counting Logic	10/2018
14	Added new data elements and descriptions as appropriate; various organizational changes	Appendix B	10/2018
15	Clarified unit type special instructions	Appendix C	10/2018
16	Removed procedure code Z7500, in combination with FI_CLAIM_TYPE_CD '04' (Outpatient), as an indicator of ER	Appendix C	10/2018

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Appendix F: Sample Encounter Volume Chart

ABC Community Hospital Volume Pivot Chart (Data for July 1, 2017 - December 31, 2017)

Sum of SVC_CNT			SVC_CAT			
Hospital_Name	NPI	PLAN_CD	S01_IP	S02_ER	S03_OP	Grand Total
ABC_COMMUNITY_HOSP	12345678	1000	181	516	6	703
		1002		10	0	10
		1004	1	34	0	35
		1006		1	0	1
		1008	127	113	0	240
		1010	0	3	0	3
		1012	0	9	0	9
		1014		1		1
		1050	0	7	1	8
		2000	0			0
		3600		2	0	2
	12345678 Total		309	696	7	1012
	98765432	1000	0			0
		1008	0		0	0
	98765432 Total		0		0	0
ABC_COMMUNITY_HOSP Total			309	696	7	1012
Grand Total			309	696	7	1012

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Hospital Directed Payments
Technical Assistance Webinar
Hospital Directed Payment Definition

California Department of Health Care Services

October 31, 2018

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Housekeeping Items

- Webinar link:
  https://zoom.us/webinar/register/WN_Tw0hvt-oTy-4x6tZSurWLQ
- All participant phone lines will be muted for the duration of the webinar.
- Questions will be addressed at the end of the short presentation.
  - Please use the Q&A function to ask questions at any time.
  - ***Please DO NOT use the Chat function.***

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Scope & Purpose

- This webinar will provide an overview of the Hospital Directed Payment "contracted services" definition for:
  - Enhanced Payment Program (EPP)
    - Reimburses designated public hospitals based on actual utilization of network contract services (or actual member assignment)
  - Private Hospital Directed Payment (PHDP)
    - Reimburses private hospitals based on actual utilization of network contract services

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"Contracted Services" Requirement

- CMS-approved SFY 2017/18 proposals for EPP and PHDP state:
  - "the State will direct the MCPs to make enhanced payments for *contracted services*" within specific classes of DPH systems or the class of private hospitals.

- For the Hospital Directed Payment definition for SFYs 2017/18 and 2018/19, visit the following link:
  - https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx

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Hospital Directed Payment Definition
SFYs 2017/18 & 2018/19

- To qualify for the directed payment, an agreement must:
  - Cover one or more defined non-excluded populations of Medi-Cal beneficiaries
  - Cover a defined set of one or more non-excluded eligible contract services
  - Specify rates of payment or include a defined methodology for calculating specific rates of payment
  - Be for a set duration of at least 120 days

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Hospital Directed Payment Definition
SFYs 2017/18 & 2018/19 (cont.)

- To qualify for the directed payment, an agreement must not:
  - Be limited to a single patient only;
  - Be limited to treatment of a single case or instance only;
  - Permit payment to be negotiated on a per patient or single instance of service basis;
  - Expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement.

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Hospital Directed Payment Definition
SFYs 2017/18 & 2018/19 (cont.)

Agreement MUST	Agreement MUST NOT
Cover one or more defined non-excluded populations of Medi-Cal beneficiaries	Be limited to a single patient only
Cover a defined set of one or more non-excluded hospital services	Be limited to treatment of a single case or instance only
Specify rates of payment or include a defined methodology for calculating specific rates of payment	Permit payment to be negotiated on a per patient or single instance of service basis
Be for a set duration of at least 120 days	Expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement

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Hospital Directed Payment Definition
SFYs 2017/18 & 2018/19 (cont.)

- Further, for delegated arrangements:
  - There must be a demonstrable "unbroken contracting path" between the MCP and the provider for:
    - The service rendered;
    - The member receiving the service; and
    - The applicable dates of service.
  - "Unbroken contracting path" means a sequence of contracts (as defined) linking the MCP and a direct subcontractor, or a series of subcontractors, to the provider.

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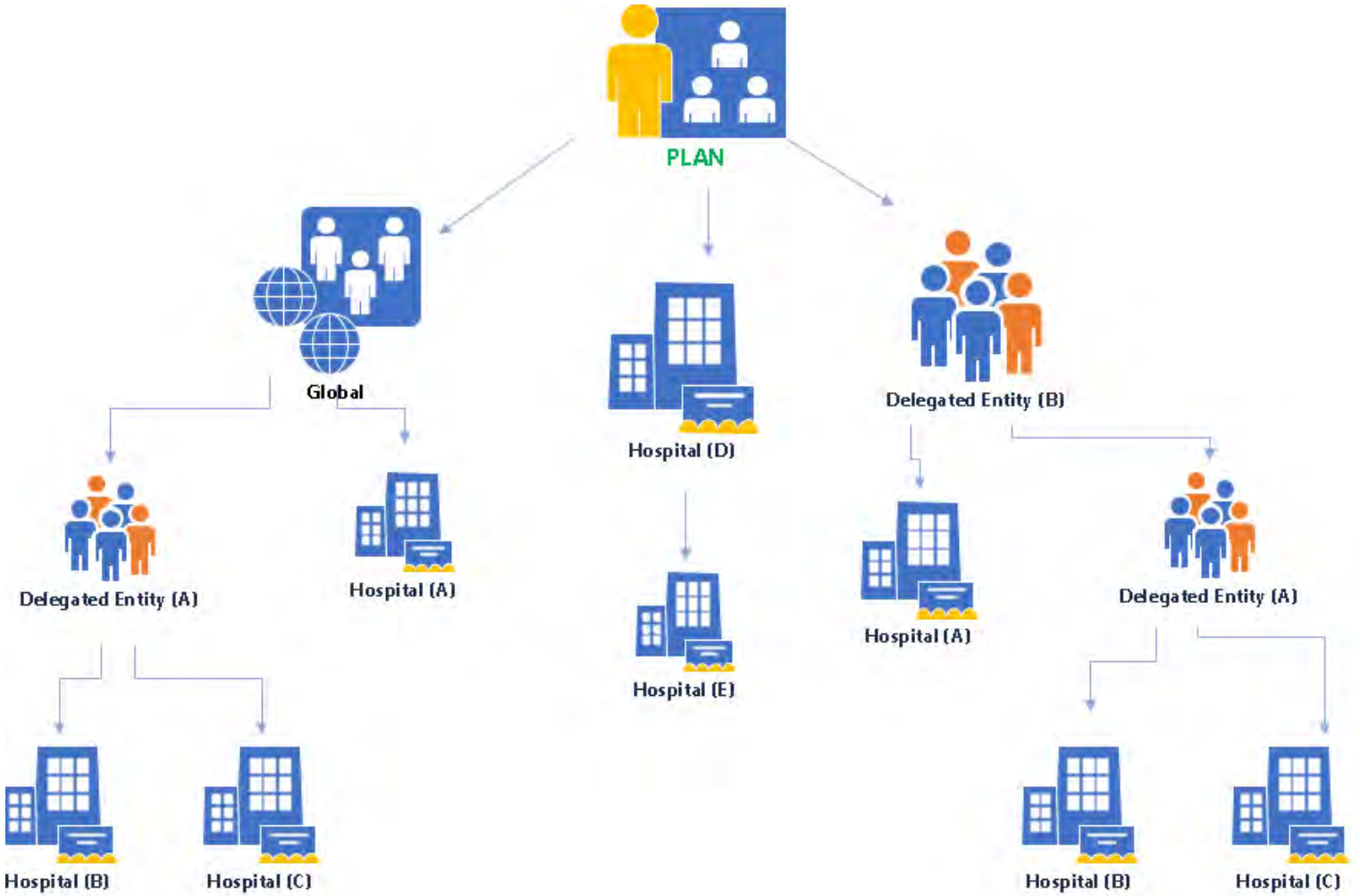
Sample Delegated Arrangements



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Hospital Directed Payment Definition
SFY 2019/20

Effective SFY 2019/20, an agreement must, in addition to the preceding standards:

- Comply with all applicable State and Federal requirements related to network providers and subcontractors

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Contract Data

- DHCS will require plans and hospitals to report contract services data for applicable encounters.
  - Guidance on the format and timing of the data request will be forthcoming.
  - Plans and hospitals will be expected to work together to provide the required data to DHCS.

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Questions?

PlanDP@dhcs.ca.gov
PrivateDP@dhcs.ca.gov
PublicDP@dhcs.ca.gov

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

6. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Secondary Agreements with the California Department of Health Care Services (DHCS) Related to Rate Changes

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chair of the Board of Directors or in his absence, the Vice Chair, to execute an Amendment(s) to the Secondary Agreement between DHCS and CalOptima related to rate changes.

Background

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

Discussion

On October 22, 2018, the DHCS sent an amendment to CalOptima that will incorporate capitation rate changes for State Supported Services the period of July 2016 to June 2017, and July 2017 to June 2018. These rate changes only pertain to services covered under the scope of CalOptima's Secondary Agreement with the DHCS.

The State Supported Services capitation rates for both periods were increased for the "Adult Expansion" aid group and were lowered for the "Adult & Family/Optional Targeted Low–Income Child" aid group.

DHCS defines State Supported Services as Current Procedural Terminology Codes 59840 through 59857 and CMS Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are all related to the provision of abortions.

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

Fiscal Impact

The capitation rates for State Supported Services listed in Amendment A-08 result in an approximate 22.9% decrease for Fiscal Year (FY) 2016-17 and 31.8% decrease for FY 2017-18 from those executed

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in Amendment A-06. Staff estimates the negative fiscal impact to Medi-Cal revenue in the amounts of $1.2 million for FY 2016-17 and $1.7 million for FY 2017-18. Since revenue accruals were made to account for such rate adjustments, the impact to CalOptima is anticipated to be budget neutral.

Rationale for Recommendation

The execution of Amendment A–08 to the Secondary Agreement is necessary to ensure CalOptima's continued responsiveness to and compliance with DHCS' requirements and expectations.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

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

11/28/2018 — **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

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)

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A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018

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

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

7. Consider Adoption of Resolution Approving Updated CalOptima 2019 Compliance Plan and Authorize the Chief Executive Officer to Approve Revised Office of Compliance Policies and Procedures

Contact

Silver Ho, Compliance Officer, (714) 246-8400

Recommended Actions

1. Adopt Resolution No. 18-1206, Approving Updated CalOptima 2019 Compliance Plan; and
2. Authorize the Chief Executive Officer to approve revised Office of Compliance Policies and Procedures.

Background

CalOptima is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including those pertaining to its Federal and State health care program operations. As part of that commitment, on December 7, 2017, the CalOptima Board of Directors reviewed and approved the updated Compliance Plan, which includes the Code of Conduct, and the Fraud, Waste, and Abuse (FWA) Plan. The Compliance Plan comprehensively addresses the fundamental elements necessary for an effective compliance program, including those elements identified by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS).

Discussion

CalOptima regularly reviews the Compliance Plan to ensure it is up-to-date and aligned with Federal and State health care program requirements and laws as well as CalOptima operations. CalOptima's Executive Director of Compliance (Compliance Officer) has reviewed the Compliance Plan and Office of Compliance Policies and Procedures to ensure consistency with applicable Federal and State health care program laws, regulations, and/or guidance.

Compliance Program Elements

Federal laws and regulations (including the federal U.S. Sentencing Guidelines, CMS Medicare Advantage regulations) and the OIG compliance guidance require that Compliance Programs be reasonably designed, implemented, and enforced, to ensure the Compliance Program is effective in preventing and detecting violations of standards or law. CalOptima's Compliance Program addresses each of the seven (7) fundamental elements of an effective Compliance Program, in addition to FWA detection, prevention, and remediation.

Written Standards

As part of the Compliance Program, CalOptima develops, maintains, and distributes to its Board Members, Employees, and First Tier, Downstream or Related Entities (FDRs) written standards in the

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form of the Compliance Plan, a Code of Conduct, and written Policies and Procedures, as further detailed in the Compliance Plan. The Compliance Plan incorporates all the elements of an effective Compliance Program as recommended by the OIG and required by CMS regulations. The Compliance Plan also incorporates a comprehensive FWA section, which establishes guidelines and procedures designed to detect, prevent, and remediate FWA in CalOptima Programs.

Oversight
The CalOptima Board of Directors (the "Board"), the governing body of CalOptima, is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the CEO, who then delegates to the Compliance Officer, a CalOptima Employee, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in the Compliance Plan. The Audit & Oversight Committee (AOC), a subcommittee of the Compliance Committee, is responsible for overseeing the internal business and delegated activities.

Training and Education
Utilizing web-based training courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and educational courses governing CalOptima's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles, or positions, within, or with, CalOptima's departments and its programs. CalOptima Board Members, Employees, and FDRs receive copies of CalOptima's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), and Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, upon appointment, hire, or commencement of a contract, as applicable, and annually thereafter.

Effective Lines of Communication and Reporting
CalOptima utilizes various methods to communicate general information, regulatory updates, and process changes from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form, including information on how to identify, report, and prevent compliance issues and FWA. CalOptima Board Members, Employees, FDRs, and/or Members receive information and reminders to report compliance concerns, questionable conduct or practices, and suspected, or actual, non-compliance issues, or FWA incidents, through one (1) of CalOptima's multiple reporting mechanisms. These reporting options, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima maintains and supports a no retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Enforcement and Disciplinary Standards
Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima's standards, requirements, or applicable laws as specified in the Compliance Program documents and related Policies and Procedures, including, but not limited to, CalOptima's policies on Performance and Behavior Standards, Corrective Action Plans, and/or Sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented

when non-compliance, or unethical behavior, is determined, and appropriate disciplinary action is implemented to address improper conduct, activity, and/or behavior.

Monitoring, Auditing, and Identification of Risks
CalOptima has implemented and continues to implement comprehensive monitoring and auditing activities related to its operations and those of its FDRs. The purpose of CalOptima's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and Federal and State laws, as well as applicable Policies and Procedures established to protect against non-compliance and potential FWA in CalOptima Programs. The Compliance Plan and related Policies and Procedures, address the monitoring and auditing processes that are carried out by CalOptima.

Response and Remediation
Once a violation, or an offense, has been detected or reported, CalOptima initiates all necessary steps to investigate, identify, and respond appropriately to the violation, or offense, and to prevent similar violations and offenses from occurring. As described in the Compliance Plan, CalOptima will conduct a timely and documented investigation, and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its Policies and Procedures to prevent the same, or similar, violation or offense, from occurring in the future.

Summary of Changes
The Compliance Plan has been updated and revised as follows:

- Clarified the responsibilities within the Office of Compliance with respect to readiness and risk assessment activities;
- Clarified the responsibilities of the AOC;
- Added language regarding data certification requirements to ensure consistency with the Medicaid Managed Care Final Rule;
- Expanded screening provisions to include the review of the CMS preclusion list in compliance with the Medicare Advantage program (Part C) and Prescription Drug Benefit Program (Part D) regulations;
- Incorporated state and federal false claims acts and whistleblower protections training requirements;
- Modified the auditing methodologies to include National Committee on Quality Assurance (NCQA) requirements;
- Added a provision regarding obligations related to overpayments;
- Expanded the provision on training for identification of FWA to include all CalOptima Members and Programs;
- Revised defined terms; and
- General formatting changes.

The Code of Conduct has been updated and revised as follows:

- Added language to anti-discrimination provision in compliance with the Medicaid Managed Care Final Rule; and
- Incorporated language to participation status provision related to preclusion screening reviews.

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Policies and Procedures

To align with the revised Compliance Plan, and consistent with applicable Federal and State health care program laws, regulations and/or guidance, the Compliance Officer, with the support of the Office of Compliance staff, updated related Policies and Procedures. The summary of changes is included in Attachment 3.

Fiscal Impact

There is no anticipated fiscal impact based on the adoption of the updates to the 2019 Compliance Plan and its related Policies and Procedures. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt CalOptima's updated 2019 Compliance Plan, and related Policies and Procedures. The updated 2019 Compliance Plan will supersede the prior updated Compliance Plan and FWA Plan approved on December 7, 2017. Minor changes have been made to the Code of Conduct and will supersede the prior updated Code of Conduct approved by the Board on October 3, 2013. Staff also recommends that the Board authorize the CEO to approve revised related Policies and Procedures to implement the updated 2019 Compliance Plan.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 18-1206, Resolution Approving CalOptima's Updated 2019 Compliance Plan
2. Draft 2019 Compliance Plan (redlined and clean versions)
3. Summary of Proposed Actions to CalOptima Office of Compliance Policies and Procedures
4. Revised Office of Compliance Policies and Procedures (redlined and clean versions)

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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RESOLUTION NUMBER 18-1206

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima

APPROVING CALOPTIMA'S UPDATED 2019 COMPLIANCE PLAN

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provides that the Board of Directors is the governing body of CalOptima, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima shall be exercised, its property controlled and its business and affairs conducted by or under the direction of the Board; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations consistent will all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima's commitment to compliant, lawful, and ethical conduct, and values the importance of compliance and ethics in Caloptima's operations; and

WHEREAS, the Board of Directors last reviewed and approved the Compliance Program on December 7, 2017 including the Compliance Plan, Code of Conduct, and related policies and procedures; and

WHEREAS, the Board of Directors reviews the Compliance Program documents on a periodic basis to ensure the Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2019 Compliance Plan, including the Fraud, Waste, and Abuse Plan, and the Code of Conduct.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance Policies and Procedures.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the Compliance Program.

Section 4. These actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 6th day of December 2018.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Vice Chair, Board of Directors
Printed Name and Title: Dr. Nikan Khatibi, Vice Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Orange County Health Authority

dba CalOptima

~~2018~~ 2019 Compliance Plan

(Revised December ~~2017~~2018)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, ~~PACE (~~Program of All-Inclusive Care for the Elderly (PACE), ~~MSSP (~~Multipurpose Senior Services Program (MSSP), and other ***CalOptima programs***.*~~.~~

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's ***First Tier***, ***Downstream***, and ***Related Entities*** (***FDRs***), such as ***health networks***, physician groups, ***participating providers*** ***and*** ~~,~~ ***suppliers***, pharmacy benefit manager (PBM), and consultants. The term ***FDR*** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the ***Centers for Medicare & Medicaid Services*** (***CMS***) and the ***Department of Health Care Services*** (***DHCS***). Such persons/entities, referred to as ***FDR*** herein, include those that directly contract with CalOptima and those that are ***Downstream*** or ***Related Entities*** (i.e., subcontracts) with CalOptima's ***First Tier Entities***.

CalOptima has developed a comprehensive ***Compliance Program*** applicable to all of CalOptima's p~~P~~rograms, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The ***Compliance Program*** incorporates all of the elements of an effective ***Compliance Program*** as recommended by the ***Office of the Inspector General*** (***OIG***) and required by ***CMS*** regulations. The ***Compliance Program*** is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima ***Board m~~M~~embers***, ***~~Employee~~employee***s, and ***FDRs*** conduct themselves in accordance with the requirements of CalOptima's ***Compliance Program***.

B. THE COMPLIANCE PLAN

This ***Compliance Plan*** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The ***Compliance Plan*** addresses the fundamental elements of an effective ***Compliance Program*** and identifies how CalOptima is implementing each of the fundamental elements of an effective ***Compliance Program*** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the ***Compliance Plan*** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** comply with contractual requirements, ethical standards, and applicable law.

This ***Compliance Plan*** is adopted by the ***Governing Body***. It was developed and is managed by the ***Executive Director of Compliance*** (referred to hereinafter as the "***Compliance Officer***") with the ***Compliance Committee***. Because the complex laws governing CalOptima and its programs are constantly evolving, the ***Compliance Plan*** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board mMembers, ~~Employee~~***employees***, and ***FDRs*** are expected to review and adhere to the requirements and standards set forth in the ***Compliance Plan***, the ***Code of Conduct***, and all related ***pPolicies and pProcedures***, as may be amended. Furthermore, ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a ***Board mMember***, ~~Employee~~***employee***, and/or ***FDR*** has/have any questions about the application, or implementation, of this ***Compliance Plan***, or questions related to the ***Code of Conduct*** or CalOptima ***pPolicies and pProcedures***, he or she should seek guidance from the ***Compliance Officer*** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***, CalOptima develops, maintains, and distributes its written standards in the form of this ***Compliance Plan***, a separate ***Code of Conduct***, and written ***pPolicies and pProcedures***.

a. Compliance Plan

As noted above, this ***Compliance Plan*** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***. This ***Compliance Plan*** also includes a comprehensive section articulating CalOptima's commitment to preventing ***Fraud***, ***Waste***, & ***Abuse*** (***FWA***), and setting forth guidelines and procedures designed to detect, prevent, and remediate ***FWA*** in the administration of ***CalOptima pPrograms***. The ***Compliance Plan*** is available on CalOptima's external website for ***Board mMembers*** and ***FDRs*** as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all ~~Employee~~***employees***.

b. Policies and Procedures

CalOptima also developed written ***pPolicies and pProcedures*** to address specific areas of CalOptima's operations, compliance activities, and ***FWA*** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are expected to be familiar with the ***pPolicies and pProcedures*** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The ***Compliance Officer***, or his/her ***dDesignee***, will ensure that ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The ***pPolicies and pProcedures*** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's ***pPolicies and pProcedures*** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's ***pPolicies and pProcedures***. ***Policies and pProcedures*** are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** receive notice when ***pPolicies and pProcedures*** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the ***Code of Conduct*** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the ***Code of Conduct*** is to articulate compliance expectations and broad principles that guide CalOptima ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** in conducting their business activities in a professional, ethical, and lawful manner. The ***Code of Conduct*** is a separate document from the ***Compliance Plan*** and can be found in Appendix A. The ***Code of Conduct*** is approved by CalOptima's Board of Directors and distributed to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** upon appointment, hire, or the commencement of the contract, and annually thereafter. New ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt and review of the ***Code of Conduct*** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the ***Compliance Program*** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the ***Compliance Officer***, the ***Compliance Committee***, the ***Audit & Oversight Committee***, and ***senior management***.

a. Governing Body

The ***CalOptima Board*** of Directors, as the ***Governing Body***, is responsible for approving, implementing, and monitoring a ***Compliance Program*** governing CalOptima's operations. The ***CalOptima Board*** delegates the ***Compliance Program*** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the ***Compliance Officer***. The ***Compliance Officer*** is an ***employee*** of CalOptima, who handles compliance oversight and activities full-time. The ***Compliance Officer***, in conjunction with the ***Compliance Committee***, are both accountable for the oversight and reporting roles and responsibilities as set forth in this ***Compliance Plan***. However, the ***CalOptima Board*** remains accountable for ensuring the effectiveness of the ***Compliance Program*** within CalOptima and monitoring the status of the ***Compliance Program*** to ensure its efficient and successful implementation.

To ensure the ***CalOptima Board*** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's ***Compliance Program***, the ***CalOptima Board***:

- Understands the content and operation of CalOptima's ***Compliance Program***;
- Approves the ***Compliance Program***, including this ***Compliance Plan*** and the ***Code of Conduct***;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the ***Compliance Program*** outcomes, including, but not limited to, results of internal and external ***audits***;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the ***Compliance Program***;

- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, ***Corrective Action Plans***, Warning Letters, and/or ***sanctions***;
- Receives regularly scheduled, periodic updates from CalOptima's ***Compliance Officer*** and ***Compliance Committee***, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the ***Compliance Program***.

The ***CalOptima Board*** reviews the measurable indicators of an effective ***Compliance Program*** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the ***CalOptima Board*** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The ***Executive Director of Compliance*** serves as the ***Compliance Officer*** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the ***Compliance Program***. The ***Compliance Officer*** reports directly to the CEO and the ***Compliance Committee*** on the activities and status of the ***Compliance Program***. The ***Compliance Officer*** has authority to report matters directly to the ***CalOptima Board*** at any time. Furthermore, the ***Compliance Officer*** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The ***Compliance Officer*** interacts with the ***CalOptima Board***, CEO, CalOptima's executive and departmental management, ***FDRs***, legal counsel, state and federal representatives, and others as required. In addition, the ***Compliance Officer*** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, ***FDR*** and internal oversight, ***p~~P~~olicies and p~~P~~rocedures***, and training on compliance activities.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Officer***, and/or his/her ***d~~D~~esignee***(s):

- Chair the ***Compliance Committee***, which shall meet no less than quarterly and assists the ***Compliance Officer*** in fulfilling his/her responsibilities;
- Ensure that the ***Compliance Program***, including this ***Compliance Plan*** and ***p~~P~~olicies and p~~P~~rocedures***, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected ***Board m~~M~~embers***, ~~Employee~~***employees***, and ***FDRs***, as appropriate;
- Oversee and monitor the implementation of the ***Compliance Program***, and provide regular reports no less than quarterly to the ***CalOptima Board*** and CEO summarizing all efforts,

including, but not limited to, the ***Compliance Committee***'s efforts to ensure adherence to the ***Compliance Program***, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and ***audit*** activities;

- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential ***FWA*** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal ***audits*** to ensure the ***Compliance Program*** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of ***Compliance Program*** activities for each of CalOptima's pPrograms, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or ***FWA*** issues, including facilitating any documentation or procedural requests by such agency~~/ies~~(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., ***DHCS*** and ***CMS***) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the ***CalOptima Board***, ~~Employee~~***employees***, and ***FDRs*** are knowledgeable about CalOptima's ***Compliance Program***, including the ***Code of Conduct***, ***pPolicies and pProcedures***, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate ***Corrective Action Plans***, ***sSanctions***, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and ***FDRs*** to ensure exclusion and preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), ~~and~~ Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List)~~)~~ has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The ***Compliance Committee***, chaired by the ***Compliance Officer***, is composed of CalOptima's ***senior management*** and operational staff, as designated by the CEO. The members of the ***Compliance Committee*** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the ***Compliance Committee*** is to implement and oversee the ***Compliance Program*** and to participate in carrying out the provisions of this ***Compliance Plan***. The ***Compliance Committee*** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the ***Compliance Program***.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Committee***:

- Maintain and update the ***Code of Conduct*** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the ***CalOptima Board***;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of ***Compliance Committee*** meetings reflecting reports made to the ***Compliance Committee*** and the ***Compliance Committee***'s decisions on the issues raised (subject to all applicable privileges);
- Review and ***Monitor*** the effectiveness of the ***Compliance Program***, including ***Monitoring*** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the ***Compliance Officer*** to ensure the adequacy of the ***Compliance Program***;
- Review, approve, and/or update ***pPolicies and pProcedures*** to ensure the successful implementation and effectiveness of the ***Compliance Program*** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and ***pPolicies and pProcedures*** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the ***Compliance Officer*** accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of ***mMmMonitoring*** and aAuditing of areas in which CalOptima is at risk of program non-compliance and/or potential ***FWA***, and ensure ***CAPs*** and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its ***FDRs*** conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the ***CalOptima Board of Directors***.

d. Audit & Oversight Committee (AOC)

The ***Audit & Oversight Committee*** (***AOC***) is a subcommittee of the ***Compliance Committee*** and is ~~chaired~~ co-led by the Director(s) of Audit & Oversight. The ***AOC*** is responsible for overseeing the delegated and internal activities of CalOptima. The ***Compliance Committee*** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima P~~p~~olicy HH.4001Δ: ~~(~~Audit & Oversight Committee~~)~~~~the *AOC* charter~~. In addition to the monthly scheduled meetings, the ***AOC*** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the ***AOC*** ~~presented~~ are approved by the majority of a quorum of the ***AOC***. A quorum is defined as one (1) over fifty percent (50%). The ***AOC*** may approve and/or implement ***Corrective Action Plans*** (***CAPs***); however, recommendations for ***FDR*** sanctioning and/or de-***delegation*** are submitted to the ***Compliance Committee*** for final approval. The ***AOC*** also contributes to external reviews and

accreditation ***audits***, such as the ***National Committee for Quality Assurance*** (***NCQA***).

Responsibilities of the ~~***Audit & Oversight Committee***~~***AOC*** with regard to ***FDRs*** include:

- Annual review, revision, and approval of the ***audit*** tools;
- Review findings of the ~~pre ***delegation audit*** and~~ readiness assessment to evaluate a potential ***FDR***'s ability to perform the delegated function(s);
- Review and approve potential ***FDR*** entities for ***delegation*** of functions;
- Ensure written agreements with each delegated ***FDR*** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and monitoring of ***FDR*** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite ***audit***;
- Ensure all ***Downstream*** and ***Related Entities*** are monitored in accordance with CalOptima oversight procedures;
- Ensure that~~Conduct~~ formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues;
- Propose s~~S~~***anctions***, subject to the ***Compliance Committee***'s approval, if an ***FDR***'s performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of ***delegation***, to the ***Compliance Committee*** for unresolved issues of compliance.

Responsibilities of the ~~***Audit & Oversight Committee***~~***AOC*** with regard to internal business functions include:

- Annual review, revision, and approval of the ~~Audit & Oversight Department Program Description~~audit work plan and ***audit*** tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual ***audit***;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the ***Compliance Officer*** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective ***Compliance***

Program;

- Receive periodic reports from the ***Compliance Officer*** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including ***audit*** findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the ***Compliance Program***. CalOptima requires that all ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's ***Code of Conduct***, compliance obligations, and relevant laws, and ***FWA***, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the ***Compliance Program***, and which courses are updated regularly to ensure that ***employees*** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The ***Compliance Officer***, or his/her ***designee*** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/***FDR***'s completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The ***Compliance Officer*** and the CalOptima management staff are responsible for ensuring that ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's ***Code of Conduct*** to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt, review, and understanding of the ***Code of Conduct*** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the ***Code of Conduct*** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each ~~person's~~ individual's personnel file~~s~~, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the ***Compliance Program***; ***FWA*** training; Health Insurance Portability and Accountability Act of 1996 (***HIPAA***) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the ***Compliance Program*** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or ***FWA*** issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's ***HIPAA*** privacy and security training course covers the administrative,

technical, and physical safeguards necessary to secure ***members***' protected health information (PHI) and personally identifiable information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the ***Compliance Program*** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each ~~Employee~~***employee***. ***Board m~~M~~embers*** and ***FDRs*** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some ***FDRs*** may be exempt or deemed to have met the ***FWA*** training and education requirement if the ***FDR*** has met the ***CMS*** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the ***Compliance Program***. These training opportunities are available to ***managers*** and ~~Employee~~***employees*** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing ***managers*** the tools and resources to train and share the information with ~~Employee~~***employees*** in their respective departments. If additional training related to ***FWA*** is required, the ***Compliance Officer***, or his/her ***designee,*** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's ***p~~P~~olicies and p~~P~~rocedures*** governing the ***Compliance Program*** and pertinent to their respective roles and responsibilities. ***Employees*** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board m~~M~~embers receive a copy of the ***Compliance Plan***, ***Code of Conduct***, and ***p~~P~~olicies and p~~P~~rocedures*** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the ***CalOptima Board***. ***Board m~~M~~embers*** may receive additional compliance training related to the ***CalOptima Board***'s role in overseeing and ensuring organizational compliance with CalOptima's ***Compliance Program***.

The ***Code of Conduct*** and ***p~~P~~olicies and p~~P~~rocedures*** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to ***FDRs*** upon commencement of the ***FDR*** contract. ***FDRs*** are required to disseminate copies of the ***Code of Conduct*** and ***p~~P~~olicies and p~~P~~rocedures*** to their ***employees***, agents, and/or ***Downstream Entities***. CalOptima may also develop compliance training and education presentations and/or roundtables for specified ***FDRs***.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the ***Compliance Program*** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to ***pPolicies and pProcedures***, contact information for the ***Compliance Officer***, relevant federal and state ***fraud*** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the ***Compliance Officer*** to CalOptima ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***members***, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the ***CalOptima Board***, ***FDRs***, ~~Employee~~***employees***, individual CalOptima departments, and ***members***.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***, which contains CalOptima's updated ***pPolicies and pProcedures***.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***mMembers***.
- Electronic Mail – The CEO, ***Compliance Officer***, or their respective ***dDesignee***, periodically sends out email communications and/or alerts to ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and/or ***mMembers***, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to ~~Employee~~***employees***.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima ~~Employee~~***employees*** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the ***Compliance Program***, ***Code of Conduct***, and/or ***pPolicies and pProcedures***.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and ***FWA*** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima ~~Employee~~***employees***.
- Written Reports – The ***Compliance Officer***, in coordination with the CEO and ***Compliance Committee***, prepares written monthly reports concerning the status of the ***Compliance Program*** to be presented to the ***CalOptima Board***.
- Direct Contact with the ***Compliance Officer*** - ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** can obtain additional compliance information directly from the ***Compliance Officer***. Any questions, which cannot be answered by the ***Compliance Officer***, shall be referred to the ***Compliance Committee***.

b. Reporting Mechanisms

CalOptima ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** have an affirmative duty and are directed in CalOptima's ***Code of Conduct*** and ***pPolicies and pProcedures*** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by ***Board mMembers***, ~~Employee~~***employees***, and/or ***FDRs*** to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an ***FDR*** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or ***FWA*** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and ***FWA*** issues are also provided to ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***mMembers*** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or ***FWA***.

Upon receipt of a report through one (1) of the listed mechanisms, the ***Compliance Officer***, ~~or~~ his/her ***designee,*** shall follow appropriate ***pPolicies and pProcedures*** to promptly review, investigate, and resolve such matters. The ***Compliance Officer***, or his/her ***designee,*** shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to a Supervisor or Manager*

CalOptima ***employees*** are encouraged to contact their immediate ***sSupervisor***, or ***mManager***, when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. The ***sSupervisor***, or ***mManager***, will promptly escalate the report to the ***Compliance Officer*** for further investigation and reporting to the CalOptima ***Compliance Committee***. If an ~~Employee~~***employee*** is concerned that his/her ***sSupervisor*** or ***mManager*** did not adequately address his/her report or complaint, the ~~Employee~~***employee*** may go directly to the ***Compliance Officer***, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. ***Members*** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or ***FWA*** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***mMembers***. ***Members*** also have access to the ***Compliance Officer*** through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline directly.

3. *Report Directly to the Compliance Officer*

The ***Compliance Officer*** is available to receive reports of suspected or actual compliance violations, or ***FWA*** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from ***Board mMembers***, ~~Employee~~***employees***, ***FDRs*** and ***members***. The ***Compliance Officer*** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. ***FDRs*** are generally contractually obligated to report suspected ***fFraud*** and ***aAbuse*** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or ***FWA***, issues in good faith. This non-retaliation policy extends to reports received from ***FDRs*** and ***mMembers***. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the ***Compliance Officer*** will review and enforce disciplinary and/or other ***Corrective Action Plans*** for violations, as appropriate, with the approval of the ***Compliance Committee***.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board mMembers, ~~Employee~~***employees***, and ***FDRs*** are provided copies of CalOptima's ***Code of Conduct*** and the ***Compliance Plan*** and have access on CalOptima's internal and external website to applicable ***pPolicies and pProcedures***, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards ~~'s Progressive Discipline Policy~~ and Office of Compliance Policies addressing ***Corrective Action Plans*** and ***sSanctions***. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board mMembers, ~~Employee~~***employees***, and ***FDRs*** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the ***Compliance Program*** documents and related ***pPolicies and pProcedures***, including CalOptima~~'s Progressive Discipline Policy~~ Policy GA.8022: Performance and Behavior Standards, as applicable. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's ***Compliance Program*** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in ***Federal and/or State hHealth cCare pPrograms***;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, ***pPolicies and pProcedures*** and/or contracts; or
- Failure to report violations or suspected violations of the ***Compliance Program***, or applicable laws, or to report suspected or actual ***FWA*** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates ***HIPAA*** and other privacy laws and/or CalOptima's ***HIPAA*** privacy and security policies, including actions that harm the privacy of ***members***, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the ***Compliance Program*** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, ***sSanctions***, and/or termination, depending on the nature and severity of the conduct, or behavior. ***Board mMembers*** may be subject to removal, ~~Employee~~***employees*** are subject to discipline, up to and including termination, and ***FDRs*** may be sanctioned, or contracts may be terminated, where

permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative ***sSanctions*** and/or penalties. Further violations could lead to suspension, preclusion, or exclusion, from participation in ***Federal and/or State hHealth cCare pPrograms***.

CalOptima ~~Employee~~***employees*** shall be evaluated annually based on their compliance with CalOptima's ***Compliance Program***. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, Audit & Oversight and ***Compliance Committee*** discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The ***Compliance Officer***, or his/her ***designee***, will collaborate with the ***Compliance Committee*** to identify areas of focus for monitoring and auditing potential non-compliant activity and ***FWA*** issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of ***FDRs***. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external ***audit*** and ***monitoring*** reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by ***CMS*** and the OIG Work Plan shall be used as resources to evaluate operational risks.

The ***Compliance Officer***, or his/her ***designee***, will work with the Chief Operating Officer, or his/her ***dDesignee***, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject to more frequent monitoring and auditing, as well as additional reporting requirements. The risk assessment process will be managed by the ***Compliance Officer***, or his/her ***dDesignee***, and presented to the ~~***Audit & Oversight Committee (AOC)***~~, and subsequently to the ***Compliance Committee***, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused ***audits*** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine ~~monitoring~~ auditing and ~~***auditing***~~ ***monitoring activities*** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima ***pPolicies and pProcedures*** to protect against non-compliance and potential ***FWA*** in ***CalOptima pPrograms***. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. ***Monitoring activities*** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An ***audit*** is 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., ***pPolicies and pProcedures***, laws, and regulations) used as base measures. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances,

regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The ***Compliance Officer***, or his/her ***designee,*** in collaboration with the ***AOC*** and ***Compliance Committee***, develops the monitoring and auditing work plans to address the risks associated with each of ***CalOptima's ~~P~~programs***.

The ***Compliance Officer***, or his/her ***designee,*** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate auditing and ***monitoring activities***. ***Audits*** for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer, or his/her ***designee,*** will coordinate the ***audits*** with internal ***audit*** staff, and, in some cases, with the assistance from an outside vendor. ***Audit*** methodologies shall be consistent with regulatory and NCQA requirements and standards. All ***audits*** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the ***audit*** review is completed, the ***audit*** team will communicate the results to the ***Compliance Officer*** and propose follow up corrective action(s), if necessary. The ***Compliance Officer***, or his/her ***designee,*** will provide reports to the CEO and the ***Compliance Committee*** concerning the results of the ***audits***. The ***AOC*** reports to the ***Compliance Officer*** and the ***Compliance Committee*** on ***audits*** that involve ***FDRs*** as discussed below. If ~~Fraud, Waste, or Abuse (~~***FWA***~~)~~ issues are identified during an ***audit***, the matter will be further investigated and resolved in a timely manner. In addition, an ***audit*** of the ***Compliance Program*** and its effectiveness should occur at least annually, and the results shall be reported to the ***CalOptima Board***.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to ***CMS***, ***DHCS***, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of ***FDRs*** who perform delegated activities. The processes that CalOptima implements to oversee, monitor, and ***audit FDRs*** are incorporated into CalOptima's written ***p~~P~~olicies and p~~P~~rocedures***, including processes involving pre-contractual evaluations and ***audits*** of ***First Tier Entities***. CalOptima may implement ***Corrective Action Plans***, ***s~~S~~anctions***, and/or revoke its ***delegation*** of duties (in a manner permitted under the contract) if CalOptima determines that an ***FDR*** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The ***Compliance Officer***, or his/her ***d~~D~~esignee***, determines the process for monitoring delegated ***FDRs*** and develops the annual monitoring and ***audit*** calendar in order to ~~validate~~validate compliance with contractual standards and regulatory requirements. The ***AOC*** is responsible for overseeing all of the delegated activities and will review the ~~***pre-delegation audit***~~readiness assessment, ensure the annual review of ***FDRs*** for delegated functions are completed, conduct formal on-going evaluation of ***FDR*** performance and compliance, ensure ***Downstream*** and ***Related Entit~~i~~es*** are monitored, and impose ***Corrective Action Plans*** and/or ***s~~S~~anctions*** if the ***FDR***'s performance fails to meet statutory and contractual standards and requirements. The ***AOC*** may recommend termination of ***delegation*** to

the ***Compliance Committee*** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or ***delegation*** agreement with a potential ***FDR***, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's ***pPolicies and pProcedures***, is completed to determine the ability of the potential ***FDR*** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, ***CMS***, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not precluded on the Preclusion List, excluded in the OIG- List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the ***DHCS*** Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the ~~Audit & Oversight Committee~~***AOC*** and subsequently the ***Compliance Committee*** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the ***delegation*** agreement specifies the activities CalOptima delegates to the ***FDRs***, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and ***audits***, and remedies, including disciplinary actions, available to CalOptima. Prior to any ***sub-delegation*** to any ***Downstream*** or ***Related Entity***, a ***First Tier Entity*** must obtain approval from CalOptima. CalOptima determines who will directly monitor the ***Downstream*** or ***Related Entity***'s compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the ***FDR*** and their contractually delegated area(s). Furthermore, ***FDRs*** will be required to complete, sign, and return attestation forms confirming the ***FDR***'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and ***FWA*** as well as exclusion and preclusion screening and ***FWA*** reporting obligations.

3. *Annual Risk Assessment*

The ***Compliance Officer***, or his/her ***dDesignee***, will ensure that~~conduct~~ an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the ***FDR***'s vulnerabilities and high-risk areas. High risk ***FDRs*** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or

complaints and appeals from the previous year will be factors that are included in the risk assessment. Any ***FDR*** deemed high risk, or vulnerable, is presented to the ***AOC*** for suggested follow-up ***audit***. ***FDRs*** determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from ***FDRs***, will be managed by the ***Compliance Officer***, or his/her ***dDesignee***, and presented to the ***AOC*** and subsequently to the ***Compliance Committee*** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the ***FDR***'s ability to provide delegated services in accordance with contractual standards and applicable state, ***CMS***, and accreditation requirements, as further detailed in CalOptima's ***pPolicies and pProcedures***. CalOptima may conduct ***audits*** of ***FDRs*** at any time. Such ***audits*** may include an evaluation of the ***FDR***'s training and education program and materials covering general compliance and ***FWA***, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk ***FDRs***, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual ***audit*** calendar; however, CalOptima does not limit its auditing schedule to only high-risk ***FDRs***.

If CalOptima has reason to believe the ***FDR***'s ability to perform a delegated function is compromised, an additional focused ***audit*** may be performed. The ***Compliance Officer***, or his/her ***designee***, may also recommend focused ***audits*** upon evaluation of non-compliant trends or reported incidents. The results of these ***audits*** will be reported to the ***AOC*** and then to the ***Compliance Committee***.

A focused ***audit*** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or ~~the~~ CalOptima's service level performance indicators;
- Failure to comply with a ***Corrective Action Plan***;
- Reported or alleged ***fFraud***, ***wWaste***, and/or ***aAbuse***;
- Significant policy variations that deviate from the CalOptima or state, ***CMS***, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to ***members*** (either suspected or reported);
- Sale, merger, or acquisition involving the ***FDR***;
- Significant changes in the management of the ***FDR***; and/or
- Changes in resources which impact CalOptima's and/or the ***FDR***'s operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The ***Compliance Officer***, or his/her ***designee***, shall submit regular reports of all monitoring, ***audit***, and corrective action activities to the ***Compliance Committee***. In instances where non-compliance is

identified, a ***Corrective Action Plan*** shall be developed by the ***FDR*** and reviewed and approved by the ***Compliance Officer***, or his/her ***dDesignee***. Every ***Corrective Action Plan*** is presented to the ***AOC*** for review. Supplemental and focused ***audits*** of ***FDRs***, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement ***sSanctions*** or require remediation by an ***FDR*** for failure to fulfill contractual obligations including development and implementation of a ***Corrective Action Plan***. Failure to cooperate with CalOptima in any manner may result in termination of the ***delegation*** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including ***pPolicies and pProcedures***, ***audit*** tools, and ***audit*** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated ***FDRs*** to monitor and track functions, performance, and ***audit*** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of ***audit*** tools;
- Implementation of a process for noticing ***FDRs*** and functional areas of ***Corrective Action Plans***;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding ***delegation*** standards, auditing, and monitoring ***FDR*** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of ***FDR*** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight ***audits*** completed within twelve (12) months; and
- ***Corrective Action Plans*** (***CAPs***) completed within the established timeframe.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's ***pPolicies and pProcedures***, CalOptima performs ***Participation Status*** Reviews by reviewing the OIG –LEIE, the GSA–SAM, and the ***DHCS*** Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure ***Board mMembers***, Employee***employees***, and/or ***FDRs*** are not excluded, or do not become excluded or precluded from participating in ***Federal and/or State health care programs***. ***Board mMembers***, Employee***employees***, and ***FDRs*** are required to disclose their ***pParticipation sStatus*** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when ***Board mMembers***, Employee***employees***, and ***FDRs*** receive notice of a suspension, preclusion, exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its ***First Tier Entities*** comply with ***Participation Status*** Review requirements with respect to their relationships with ***Downstream Entities***, including without limitation, the delegated credentialing and re-credentialing processes.

The ***Compliance Officer***, or his/her ***designee***, will review reports from Employee***employees*** responsible for conducting the ***Participation Status*** Reviews to ensure Employee***employees*** record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the ***Compliance Officer*** of affirmative findings of a person, or entity's, failure to meet the ***Participation Status*** Review requirements. If CalOptima learns that any prospective, or current, ***Board mMember***, Employee***employee***, or ***FDR*** has been proposed for exclusion, or excluded, or precluded, CalOptima will promptly remove him/her/the ***FDR*** from ***CalOptima's Programs programs*** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, exclusion, preclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies and/or contract terms. The ***Compliance Officer***, or his/her ***designee***, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's ***Compliance Program*** and/or ***FWA*** issues, the ***Compliance Officer***, or his/her ***designee***, shall, upon promptly verifying the facts related to the violation or likely violation, notify the ***Compliance Committee***, as appropriate. The ***Compliance Committee*** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, ***sSanctions***, termination of any agreement and/or any other corrective action (including repayment of ***oOverpayments***) consistent with applicable ***pPolicies and pProcedures***, subject to consultation with legal counsel and/or notifying the ***Governing Body***, as appropriate;
- Implementing education and training programs for ***Board mMembers***, ~~Employee~~***employees***, and/or ***FDRs***, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's ***Compliance Plan***, ***Code of Conduct***, and/or relevant ***pPolicies and pProcedures*** in an effort to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the ***Compliance Officer*** and the ***Compliance Committee*** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable ***pPolicies and pProcedures*** after considering such recommendations. The ***Compliance Officer***, or his/her ***dDesignee***, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to ***DHCS*** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning ***fFraud*** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

activity indicates that ***f~~F~~raud*** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a ***f~~F~~raud*** alert is received, CalOptima shall review its ***delegation*** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the ***delegation*** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a ***f~~F~~raud*** alert. With the issuance of a ***f~~F~~raud*** alert, ***CMS*** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged ***f~~F~~raud*** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, ***DHCS*** Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of ***Federal and/or State health care programs*** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., ***f~~F~~raud*** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, ***DHCS***, ***CMS***, and ***CMS***' ***designee***, regarding monitoring of ***FDRs*** within CalOptima's network that ***DHCS***, or ***CMS***, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent ~~Fraud, Waste, and Abuse (~~***FWA***~~)~~ within a CalOptima program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of ***FWA*** activity. CalOptima shall assess all ***FDRs*** for potential ***o~~O~~verpayments*** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return ***o~~O~~verpayments*** consistent with applicable laws and regulatory guidance. Should revisions to reported data be required, CalOptima and/or FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of ***o~~O~~verpayment*** determinations to regulatory agencies, as required by law.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of ***FWA*** are components of CalOptima's ***Compliance Program***. ***FWA*** activities are implemented and overseen by CalOptima's ***Compliance Officer***, or his/her ***designee***, in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for ***FWA*** investigations. The ***Compliance Officer***, or his/her ***designee***, reports ***FWA*** activities to the CalOptima ***Compliance Committee***, CEO, the ***CalOptima Board***, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent, and remediate ***FWA***. In addition, CalOptima promptly investigates suspected ***FWA*** issues and implements disciplinary, or corrective, action to avoid recurrence of ***FWA*** issues. The objective of the ***FWA*** program is to ensure that the scope of benefits covered by the ***CalOptima pPrograms*** is appropriately delivered to ***mMembers*** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify ***FWA*** and promptly respond appropriately to such incidents of ***FWA***.

I.TRAINING

As detailed above, ***FWA*** training is provided to all ***Board mMembers*** and ~~Employee~~***employees*** as part of the overall compliance training courses in order to help detect, prevent, and remediate ***FWA***. ***FDRs*** are also required to complete ***FWA*** training, as described above. CalOptima's ***FWA*** training provides guidance to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** on how to identify activities and behaviors that would constitute ***FWA*** and how to report suspected, or actual, ***FWA*** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual ***FWA***;
- Examples of the most common types of member ***FWA*** (see Appendix B, attached hereto and incorporated herein) and ***FDR FWA*** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify ***FWA*** in ***CalOptima~~'s PACE health P~~program~~s*** (*e.g.*, suspicious activities suggesting ~~PACE participants~~CalOptima members, or their family ***members***, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in ~~the PACE~~the ***CalOptima programs***, etc.);
- Information on how to identify potential prescription drug ***FWA*** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug

claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential ***FWA*** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for ***FDRs***, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the ***False Claims Act*** and CalOptima's requirement to train ~~Employee~~***employees*** and ***FDR***s on the ***False Claims Act*** and other applicable ***FWA*** laws.

CalOptima shall provide ***Board m~~M~~embers***, ~~Employee~~***employees***, ***FDRs***, and ***members*** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of ***FWA***. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. ***Members***, ***FDRs***, ~~Employee~~***employees***, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect ***FWA*** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record ***audits***;
- ***Member*** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- ~~Monitoring~~ Auditing and ***monitoring~~auditing~~ activities***;
- Monitoring external health care ***FWA*** cases and determining if CalOptima's ***FWA*** Program can be strengthened with information gleaned from the case activity; and/or

- Internal and external surveys, reviews, and ***audits***.

b. Data Analytics

CalOptima uses technology and data analysis to reduce ***FWA*** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect ***FDRs*** based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare-Medicaid ~~Advantage Part D~~ programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that Federal and State ~~Medicare~~ funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of ***FWA***.

The following trends will be reviewed and flagged for potential ***FWA***, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by ***members*** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;

- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected ***FWA***. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a ***member*** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of ***FWA***. The presence of several indicators may suggest ***FWA***, but further investigation is needed to determine if a suspicion of ***FWA*** actually exists. The following list

below highlights common industry indicators and red flags that are used to determine whether or not to investigate an ***FDR*** or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the ***member***/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the ***FWA*** database and a report is generated and submitted to the ***Compliance Officer***, ***Compliance Committee***, and CEO.

III.INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected ***FWA*** or detects ***FWA*** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an ***FDR*** to obtain relevant information;
- SIU, or a ***designee***, interviews the individual who reported the ***FWA***, affected ***members*** and/or ***FDRs***, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of ***FDR*** enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;

- After an allegation is logged into the Fraud Tracking ~~System~~Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database~~System~~ shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the ***Compliance Officer*** and ***Compliance Committee*** for discussion and approval.

IV.FINDINGS, RESPONSE, AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of ***FWA***, need for contract amendment, education and training requirement, recommendation of focused ***audits***, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential ***FWA*** issue has been identified, the SIU will track and trend the ***FWA*** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the ***Compliance Committee*** on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's ***p~~P~~olicies and p~~P~~rocedures***, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima ***p~~P~~olicies and p~~P~~rocedures***, CalOptima shall take appropriate disciplinary, or corrective, action against ***Board m~~M~~embers***, ~~Employee~~***employees***, and/or ***FDRs*** related to validated instances of ***FWA***. CalOptima will also assess ***FDRs*** for potential ***o~~O~~verpayments*** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the ***Compliance Committee***, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial ***sanctions***, regulatory reporting, ***Corrective Action Plans***, or termination of the ***delegation*** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first ***Compliance Committee*** following the date of identification of the suspected ***FWA***, the date of report to ***DHCS***, or the date of ***FWA*** substantiation by ***DHCS*** subsequent to the report. If vulnerability is identified through a single ***FWA*** incident, the correction action may be applied universally.

V.REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential ***FWA*** to appropriate regulatory agencies, or their designated program integrity contractors, including the ***CMS*** MEDIC, ***DHCS*** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. ***FDRs*** shall report ***FWA*** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to

timely report to applicable enforcement agencies. Significant program non-compliance, or suspected ***FWA***, should be reported to ***CMS*** and/or ***DHCS***, as soon as possible after discovery, but no later than ten (10) working days to ***DHCS*** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect, or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond ~~the~~ CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of ***FWA***;
- Patterns of ***FWA*** threatening the life, or well-being, of CalOptima ***members***; and/or
- Schemes with large financial risk to CalOptima, or its ***members***.

VI.ANNUAL EVALUATION

CalOptima's ***Compliance Committee*** shall periodically review and evaluate the ***FWA*** activities and its effectiveness as part of the overall ***Compliance Program*** ***audit*** ~~monitoring~~ and ***monitoring*** ~~***audit***~~ ***activities***. Revisions should be made based on industry changes, trends in ***FWA*** activities (locally and nationally), the OIG Work Plan, the CalOptima ***Compliance Plan***, and other input from applicable sources.

VII.RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of ***FWA*** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of ***FWA*** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII.CONFIDENTIALITY

CalOptima and its ***FDRs*** shall maintain all information associated with suspected, or actual, ***FWA*** in confidential files, which may only be released in accordance with applicable laws and CalOptima ***p*** ~~***P***~~***olicies and p*** ~~***P***~~***rocedures***. All participants and attendees of CalOptima's Quality Improvement Committee, ***Compliance Committee***, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the ***Compliance Program***, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the ***Compliance Program*** against the elements of an effective ***Compliance Program*** as recommended by OIG and required by ***CMS*** regulations. The following areas will be reviewed:

- ***Policies and procedures***;
- ***Compliance Officer*** and ***Compliance Committee***;
- Training and education of ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing;
- ***Delegation*** oversight;
- Exclusion and preclusion screening process; and
- Prompt responses to detected offenses.

The ***Compliance Program*** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with ***sSenior mManagement***, the ***Compliance Committee***, and the ***CalOptima Board***. Updates to the ***Compliance Program*** will be based on the results of the evaluation and will be referred to the ***CalOptima Board*** for review and approval.

~~E.~~I. FILING SYSTEMS

The ***Compliance Officer***, or his/her ***designee***, shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

a. Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- ***Compliance Plan*** and any amendments;
- Any ***Compliance Program p~~P~~olicies and p~~P~~rocedures*** issued after the initiation of the ***Compliance Program***;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, ***Compliance Plan***, ***Code of Conduct*** and/or appointment of the ***Compliance Officer***;
- All non-privileged communications to the ***Compliance Officer*** (original);
- All ***Compliance Committee*** and ***CalOptima Board*** minutes in which compliance issues are discussed; and/or
- Any other written records of the ***AOC***, or other oversight activities (originals if generated by the ***Compliance Officer***).

b. Information and Education File

This file shall contain copies of the following (unless originals specified):

- ***FDR*** training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- ***Board m~~M~~ember*** and ~~Employee~~***employee*** training records, attestations, and attendance records are maintained by the Human Resources Department.
- Educational materials provided to ***Board m~~M~~embers***, ~~Employee~~***employees***, and ***FDRs***;
- Notices, ***f~~F~~raud*** alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

c. Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to compliance reports including reports to the Compliance and Ethics Hotline

and/or to the ***Compliance Officer*** (originals);

- Records relating to periodic monitoring and auditing of the ***Compliance Program*** (originals);
- Records relating to ***Board mMember***, ~~Employee~~***employee***, and ***FDR Participation Status*** Review or background checks (originals except where ***FDRs*** perform ***Participation Status*** Reviews);
- Records relating to established periodic monitoring mechanisms;
- All documents pertaining to the enforcement of the ***Compliance Program***, including, investigations and disciplinary and/or corrective actions; and/or
- All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

d. Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the ***Compliance Officer***, legal counsel, and the ***Compliance Committee***, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the ***Compliance Officer***;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning ***FDR delegation*** agreement interpretations and remedies available to CalOptima.

e. Document Retention

All of the documents to be maintained in the filing system described above shall be retained for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by ***HIPAA*** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) ***pPolicies and pProcedures*** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by ***HIPAA***; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under ***HIPAA***; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

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Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** 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 CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board mMembers, eEmployees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, eEmployees and cContractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, eEmployees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss eEmployee and cContractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, eEmployees, and cContractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Principle	Standard
	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, eEmployees and cContractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, eEmployees, and cContractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and cContractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of mMember care. Employees and cContractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and cContractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's fFacilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled mMembers. **Emergency Treatment** Employees and cContractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

Principle	Standard
	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its pPhysician gGroups, its hHealth nNetworks and tThird pParty aAdministrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the sState hHearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and cContractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima pPolicies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, eEmployees and cContractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, eEmployee, or cContractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima ~~or~~ about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and cContractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.
Public Integrity	**Public Records**

Principle	Standard
CalOptima and its Board members and eEmployees shall comply with laws and regulations governing public agencies.	CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima pPolicies. **Public Funds** CalOptima, its Board members, and eEmployees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and eEmployees shall comply with applicable law and CalOptima pPolicies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and eEmployees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code, Sections 54950 et seq.
Confidentiality Board members, eEmployees, and ecContractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, eEmployees and cContractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, eEmployees and cContractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files**

Principle	Standard
	Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, cContractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, cContractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, cEmployees, and cContractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, cEmployees, cContractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and cEmployees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima ~~Policies~~policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima ~~Policies~~ policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

Principle	Standard
	Third-Party Sponsored Events CalOptima's joint participation in cContractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Policies policies on this subject. In no event, shall CalOptima participate in any joint cContractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at cContractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Policiespolicies. **Provision of Gifts to Government Agencies** Board members, cEmployees, and cContractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and cEmployees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated cEmployees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and cEmployees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any cContractor, association of cContractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any cContractor or association of cContractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any cContractor or association of cContractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, eEmployees and cContractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, ~~national origin,~~ age, marital status, gender (which includes sex, gender identity, and gender expression), ~~gender,~~ sexual orientation, ~~gender identity,~~ health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, pPhysician gGroups, and hHealth nNetworks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that eEmployees, cContractors, pProviders, and sSuppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, eEmployees, and cContractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of eEmployees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, eEmployees and cContractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State hHealth cCare program. Employees, ~~and~~ individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its hHealth nNetworks, pPhysician gGroups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all eEmployees, cContractors, hHealth nNetworks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its mMembers have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the ~~Executive Director, Department of Compliance~~ Compliance Officer and/or their sSupervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and eEmployees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima ~~Policies~~ policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by ~~Legal~~ legal ~~Counsel~~counsel.
Compliance Program Reporting Board members, eEmployees, and cContractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, eEmployees and cContractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own ~~Policies~~ policies in accordance with CalOptima's reporting ~~Policies~~ policies and its Compliance Plan. Such reports may be made to a sSupervisor or ~~,~~ the ~~Executive Director, Office of~~ Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, ~~Policies~~ policies, and/or applicable statutes,

Principle	Standard
	regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's ~~Policies~~policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, c~~E~~mployees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima c~~E~~mployees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination ~~or~~, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, c~~E~~mployees, and c~~C~~ontractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable ~~Policies~~policies.

Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain cCovered sServices.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a ~~Covered~~ covered ~~Service~~ service for purposes other than the purpose for which it was described including use of such cCovered sService.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive cCovered sServices.	Hotline reports; internal reports; reports by hHealth nNetworks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping.	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription.	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for cCovered sServices that are substantially and demonstrably in excess of any individual's usual charges for such cCovered sServices.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for cCovered sServices that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for cCovered ~~Services~~ services that are in excess of the quantity that is mMedically nNecessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for cCovered sServices that are ~~that are~~ billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for cCovered sServices that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for cCovered sServices that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for cCovered sServices.	Member report; hotline report; oversight audits.
P09	Billing a member for cCovered sServices without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.

P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.
FDR FRAUD, WASTE OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P13	False certification of mMedical nNecessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate mMinimum sStandards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal mMember for sServices.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment-cCovered sServices that are not actually provided to ~~beneficiary~~member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a m~~M~~ember's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a m~~M~~ember's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a m~~M~~ember's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling m~~M~~ember's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for c~~C~~overed s~~S~~ervices that are not actually provided to the m~~M~~ember for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using m~~M~~ember's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima
AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.
I attended the annual Compliance Training Session on _____.

_____
Print Name

_____
Signature

_____
Date

RETURN TO THE COMPLIANCE OFFICER

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima pProgram, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fFraud, because the distinction between "fFraud" and "aAbuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means 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 (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit &and 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 Committeethe AOC charter.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code, Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima pProgram.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, and the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare

program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, eEmployees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and pPolicies and pProcedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, eEmployees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance ~~for compliance~~ and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code~~,~~ Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the

Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is 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 ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima pProgram benefit, below the level of the arrangement between CalOptima and a fFirst tTier eEntity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all sSenior mManagement, officers, mManagers, sSupervisors and other employed personnel, as well as temporary e Employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means 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 mMember under a CalOptima pProgram.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means 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.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Overpayment ("Overpayment") means a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its hHealth nNetworks for items or services furnished to mMembers. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State hHealth cCare pPrograms as provided in CalOptima pPolicies and pProcedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, eEmployees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State hHealth cCare pPrograms.

Policies and Procedures ("Policies and Procedures") means CalOptima's written pPolicies and pProcedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means 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 mMembers 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 ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or

its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima pPrograms.

Senior Management ("Senior Management") means any cEmployee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.

Sub-delegation ("Sub-delegation") means the process by which a fFirst tTier cEntity expressly grants, by formal agreement, to a dDownstream cEntity the authority to carry out one or more functions that would otherwise be required to be performed by the fFirst tTier cEntity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an cEmployee in a position representing CalOptima who has one (1) or more cEmployees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima cEmployee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a cContractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima pProgram. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority

dba CalOptima

2019 Compliance Plan

(Revised December 2018)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and other ***CalOptima programs***.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's ***First Tier***, ***Downstream***, and ***Related Entities*** (***FDRs***), such as ***health networks***, physician groups, ***participating providers and suppliers***, pharmacy benefit manager (PBM), and consultants. The term ***FDR*** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the ***Centers for Medicare & Medicaid Services*** (***CMS***) and the ***Department of Health Care Services*** (***DHCS***). Such persons/entities, referred to as ***FDR*** herein, include those that directly contract with CalOptima and those that are ***Downstream*** or ***Related Entities*** (i.e., subcontracts) with CalOptima's ***First Tier Entities***.

CalOptima has developed a comprehensive ***Compliance Program*** applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The ***Compliance Program*** incorporates all of the elements of an effective ***Compliance Program*** as recommended by the ***Office of the Inspector General*** (***OIG***) and required by ***CMS*** regulations. The ***Compliance Program*** is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima ***Board members***, ***employee***s, and ***FDRs*** conduct themselves in accordance with the requirements of CalOptima's ***Compliance Program***.

B. THE COMPLIANCE PLAN

This ***Compliance Plan*** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The ***Compliance Plan*** addresses the fundamental elements of an effective ***Compliance Program*** and identifies how CalOptima is implementing each of the fundamental elements of an effective ***Compliance Program*** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the ***Compliance Plan*** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its ***Board members***, ***employees***, and ***FDRs*** comply with contractual requirements, ethical standards, and applicable law.

This ***Compliance Plan*** is adopted by the ***Governing Body***. It was developed and is managed by the ***Executive Director of Compliance*** (referred to hereinafter as the "***Compliance Officer***") with the ***Compliance Committee***. Because the complex laws governing CalOptima and its programs are constantly evolving, the ***Compliance Plan*** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board members, ***employees***, and ***FDRs*** are expected to review and adhere to the requirements and standards set forth in the ***Compliance Plan***, the ***Code of Conduct***, and all related ***policies and procedures***, as may be amended. Furthermore, ***Board members***, ***employees***, and ***FDRs*** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a ***Board member***, ***employee***, and/or ***FDR*** has/have any questions about the application, or implementation, of this ***Compliance Plan***, or questions related to the ***Code of Conduct*** or CalOptima ***policies and procedures***, he or she should seek guidance from the ***Compliance Officer*** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of ***Board members***, ***employees***, and ***FDRs***, CalOptima develops, maintains, and distributes its written standards in the form of this ***Compliance Plan***, a separate ***Code of Conduct***, and written ***policies and procedures***.

a. Compliance Plan

As noted above, this ***Compliance Plan*** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima ***Board members***, ***employees***, and ***FDRs***. This ***Compliance Plan*** also includes a comprehensive section articulating CalOptima's commitment to preventing ***Fraud***, ***Waste***, & ***Abuse*** (***FWA***), and setting forth guidelines and procedures designed to detect, prevent, and remediate ***FWA*** in the administration of ***CalOptima programs***. The ***Compliance Plan*** is available on CalOptima's external website for ***Board members*** and ***FDRs*** as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all ***employees***.

b. Policies and Procedures

CalOptima also developed written ***policies and procedures*** to address specific areas of CalOptima's operations, compliance activities, and ***FWA*** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to ***Board members***, ***employees***, and ***FDRs*** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. ***Board members***, ***employees***, and ***FDRs*** are expected to be familiar with the ***policies and procedures*** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The ***Compliance Officer***, or his/her ***designee***, will ensure that ***Board members***, ***employees***, and ***FDRs*** are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The ***policies and procedures*** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's ***policies and procedures*** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's ***policies and procedures***. ***Policies and procedures*** are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to ***Board members***, ***employees***, and ***FDRs***. ***Board members***, ***employees***, and ***FDRs*** receive notice when ***policies and procedures*** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the ***Code of Conduct*** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the ***Code of Conduct*** is to articulate compliance expectations and broad principles that guide CalOptima ***Board members***, ***employees***, and ***FDRs*** in conducting their business activities in a professional, ethical, and lawful manner. The ***Code of Conduct*** is a separate document from the ***Compliance Plan*** and can be found in Appendix A. The ***Code of Conduct*** is approved by CalOptima's Board of Directors and distributed to ***Board members***, ***employees***, and ***FDRs*** upon appointment, hire, or the commencement of the contract, and annually thereafter. New ***Board members***, ***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt and review of the ***Code of Conduct*** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the ***Compliance Program*** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the ***Compliance Officer***, the ***Compliance Committee***, the ***Audit & Oversight Committee***, and ***senior management***.

a. Governing Body

The ***CalOptima Board*** of Directors, as the ***Governing Body***, is responsible for approving, implementing, and monitoring a ***Compliance Program*** governing CalOptima's operations. The ***CalOptima Board*** delegates the ***Compliance Program*** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the ***Compliance Officer***. The ***Compliance Officer*** is an ***employee*** of CalOptima, who handles compliance oversight and activities full-time. The ***Compliance Officer***, in conjunction with the ***Compliance Committee***, are both accountable for the oversight and reporting roles and responsibilities as set forth in this ***Compliance Plan***. However, the ***CalOptima Board*** remains accountable for ensuring the effectiveness of the ***Compliance Program*** within CalOptima and monitoring the status of the ***Compliance Program*** to ensure its efficient and successful implementation.

To ensure the ***CalOptima Board*** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's ***Compliance Program***, the ***CalOptima Board***:

- Understands the content and operation of CalOptima's ***Compliance Program***;
- Approves the ***Compliance Program***, including this ***Compliance Plan*** and the ***Code of Conduct***;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the ***Compliance Program*** outcomes, including, but not limited to, results of internal and external ***audits***;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the ***Compliance Program***;

- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, ***Corrective Action Plans***, Warning Letters, and/or ***sanctions***;
- Receives regularly scheduled, periodic updates from CalOptima's ***Compliance Officer*** and ***Compliance Committee***, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the ***Compliance Program***.

The ***CalOptima Board*** reviews the measurable indicators of an effective ***Compliance Program*** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the ***CalOptima Board*** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The ***Executive Director of Compliance*** serves as the ***Compliance Officer*** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the ***Compliance Program***. The ***Compliance Officer*** reports directly to the CEO and the ***Compliance Committee*** on the activities and status of the ***Compliance Program***. The ***Compliance Officer*** has authority to report matters directly to the ***CalOptima Board*** at any time. Furthermore, the ***Compliance Officer*** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The ***Compliance Officer*** interacts with the ***CalOptima Board***, CEO, CalOptima's executive and departmental management, ***FDRs***, legal counsel, state and federal representatives, and others as required. In addition, the ***Compliance Officer*** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, ***FDR*** and internal oversight, ***policies and procedures***, and training on compliance activities.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Officer***, and/or his/her ***designee***(s):

- Chair the ***Compliance Committee***, which shall meet no less than quarterly and assists the ***Compliance Officer*** in fulfilling his/her responsibilities;
- Ensure that the ***Compliance Program***, including this ***Compliance Plan*** and ***policies and procedures***, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected ***Board members***, ***employees***, and ***FDRs***, as appropriate;
- Oversee and monitor the implementation of the ***Compliance Program***, and provide regular reports no less than quarterly to the ***CalOptima Board*** and CEO summarizing all efforts,

including, but not limited to, the ***Compliance Committee***'s efforts to ensure adherence to the ***Compliance Program***, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and ***audit*** activities;

- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential ***FWA*** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal ***audits*** to ensure the ***Compliance Program*** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of ***Compliance Program*** activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or ***FWA*** issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., ***DHCS*** and ***CMS***) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the ***CalOptima Board***, ***employees***, and ***FDRs*** are knowledgeable about CalOptima's ***Compliance Program***, including the ***Code of Conduct***, ***policies and procedures***, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate ***Corrective Action Plans***, ***sanctions***, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and ***FDRs*** to ensure exclusion and preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The ***Compliance Committee***, chaired by the ***Compliance Officer***, is composed of CalOptima's ***senior management*** and operational staff, as designated by the CEO. The members of the ***Compliance Committee*** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the ***Compliance Committee*** is to implement and oversee the ***Compliance Program*** and to participate in carrying out the provisions of this ***Compliance Plan***. The ***Compliance Committee*** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the ***Compliance Program***.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Committee***:

- Maintain and update the ***Code of Conduct*** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the ***CalOptima Board***;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of ***Compliance Committee*** meetings reflecting reports made to the ***Compliance Committee*** and the ***Compliance Committee***'s decisions on the issues raised (subject to all applicable privileges);
- Review and ***Monitor*** the effectiveness of the ***Compliance Program***, including ***Monitoring*** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the ***Compliance Officer*** to ensure the adequacy of the ***Compliance Program***;
- Review, approve, and/or update ***policies and procedures*** to ensure the successful implementation and effectiveness of the ***Compliance Program*** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and ***policies and procedures*** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the ***Compliance Officer*** accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of ***monitoring*** and auditing of areas in which CalOptima is at risk of program non-compliance and/or potential ***FWA***, and ensure ***CAPs*** and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its ***FDRs*** conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the ***CalOptima Board of Directors***.

d. Audit & Oversight Committee (AOC)

The ***Audit & Oversight Committee*** (***AOC***) is a subcommittee of the ***Compliance Committee*** and is co-led by the Director(s) of Audit & Oversight. The ***AOC*** is responsible for overseeing the delegated and internal activities of CalOptima. The ***Compliance Committee*** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the ***AOC*** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the ***AOC*** are approved by the majority of a quorum of the ***AOC***. A quorum is defined as one (1) over fifty percent (50%). The ***AOC*** may approve and/or implement ***Corrective Action Plans*** (***CAPs***); however, recommendations for ***FDR*** sanctioning and/or de-***delegation*** are submitted to the ***Compliance Committee*** for final approval. The ***AOC*** also contributes to external reviews and accreditation ***audits***, such as the

National Committee for Quality Assurance (***NCQA***).

Responsibilities of the ***AOC*** with regard to ***FDRs*** include:

- Annual review, revision, and approval of the ***audit*** tools;
- Review findings of the readiness assessment to evaluate a potential ***FDR***'s ability to perform the delegated function(s);
- Review and approve potential ***FDR*** entities for ***delegation*** of functions;
- Ensure written agreements with each delegated ***FDR*** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and monitoring of ***FDR*** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite ***audit***;
- Ensure all ***Downstream*** and ***Related Entities*** are monitored in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues;
- Propose ***sanctions***, subject to the ***Compliance Committee***'s approval, if an ***FDR***'s performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of ***delegation***, to the ***Compliance Committee*** for unresolved issues of compliance.

Responsibilities of the ***AOC*** with regard to internal business functions include:

- Annual review, revision, and approval of the audit work plan and ***audit*** tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual ***audit***;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the ***Compliance Officer*** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective ***Compliance Program***;

- Receive periodic reports from the ***Compliance Officer*** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including ***audit*** findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the ***Compliance Program***. CalOptima requires that all ***Board members***, ***employees***, and ***FDRs*** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's ***Code of Conduct***, compliance obligations, and relevant laws, and ***FWA***, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the ***Compliance Program***, and which courses are updated regularly to ensure that ***employees*** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The ***Compliance Officer,*** or his/her ***designee*** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/***FDR***'s completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The ***Compliance Officer*** and the CalOptima management staff are responsible for ensuring that ***Board members***, ***employees***, and ***FDRs*** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's ***Code of Conduct*** to ***Board members***, ***employees***, and ***FDRs***. ***Board members***, ***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt, review, and understanding of the ***Code of Conduct*** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the ***Code of Conduct*** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires ***Board members***, ***employees***, and ***FDRs***, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the ***Compliance Program***; ***FWA*** training; Health Insurance Portability and Accountability Act of 1996 (***HIPAA***) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the ***Compliance Program*** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or ***FWA*** issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's ***HIPAA*** privacy and security training course covers the administrative,

technical, and physical safeguards necessary to secure ***members***' protected health information (PHI) and personally identifiable information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the ***Compliance Program*** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each ***employee***. ***Board members*** and ***FDRs*** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some ***FDRs*** may be exempt or deemed to have met the ***FWA*** training and education requirement if the ***FDR*** has met the ***CMS*** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the ***Compliance Program***. These training opportunities are available to ***managers*** and ***employees*** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing ***managers*** the tools and resources to train and share the information with ***employees*** in their respective departments. If additional training related to ***FWA*** is required, the ***Compliance Officer,*** or his/her ***designee,*** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's ***policies and procedures*** governing the ***Compliance Program*** and pertinent to their respective roles and responsibilities. ***Employees*** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board members receive a copy of the ***Compliance Plan***, ***Code of Conduct***, and ***policies and procedures*** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the ***CalOptima Board***. ***Board members*** may receive additional compliance training related to the ***CalOptima Board***'s role in overseeing and ensuring organizational compliance with CalOptima's ***Compliance Program***.

The ***Code of Conduct*** and ***policies and procedures*** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to ***FDRs*** upon commencement of the ***FDR*** contract. ***FDRs*** are required to disseminate copies of the ***Code of Conduct*** and ***policies and procedures*** to their ***employees***, agents, and/or ***Downstream Entities***. CalOptima may also develop compliance training and education presentations and/or roundtables for specified ***FDRs***.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the ***Compliance Program*** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to ***policies and procedures***, contact information for the ***Compliance Officer***, relevant federal and state ***fraud*** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the ***Compliance Officer*** to CalOptima ***Board members***, ***employees***, ***FDRs***, and ***members***, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the ***CalOptima Board***, ***FDRs***, ***employees***, individual CalOptima departments, and ***members***.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to ***Board members***, ***employees***, and ***FDRs***, which contains CalOptima's updated ***policies and procedures***.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to ***Board members***, ***employees***, ***FDRs***, and ***members***.
- Electronic Mail – The CEO, ***Compliance Officer***, or their respective ***designee***, periodically sends out email communications and/or alerts to ***Board members***, ***employees***, ***FDRs***, and/or ***members***, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to ***employees***.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima ***employees*** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the ***Compliance Program***, ***Code of Conduct***, and/or ***policies and procedures***.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and ***FWA*** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima ***employees***.
- Written Reports – The ***Compliance Officer***, in coordination with the CEO and ***Compliance Committee***, prepares written monthly reports concerning the status of the ***Compliance Program*** to be presented to the ***CalOptima Board***.
- Direct Contact with the ***Compliance Officer*** - ***Board members***, ***employees***, and ***FDRs*** can obtain additional compliance information directly from the ***Compliance Officer***. Any questions, which cannot be answered by the ***Compliance Officer***, shall be referred to the ***Compliance Committee***.

b. Reporting Mechanisms

CalOptima ***Board members***, ***employees***, and ***FDRs*** have an affirmative duty and are directed in CalOptima's ***Code of Conduct*** and ***policies and procedures*** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by ***Board members***, ***employees***, and/or ***FDRs*** to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an ***FDR*** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or ***FWA*** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and ***FWA*** issues are also provided to ***Board members***, ***employees***, ***FDRs***, and ***members*** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or ***FWA***.

Upon receipt of a report through one (1) of the listed mechanisms, the ***Compliance Officer***, or his/her ***designee,*** shall follow appropriate ***policies and procedures*** to promptly review, investigate, and resolve such matters. The ***Compliance Officer,*** or his/her ***designee,*** shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to a Supervisor or Manager*

CalOptima ***employees*** are encouraged to contact their immediate ***supervisor***, or ***manager***, when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. The ***supervisor***, or ***manager***, will promptly escalate the report to the ***Compliance Officer*** for further investigation and reporting to the CalOptima ***Compliance Committee***. If an ***employee*** is concerned that his/her ***supervisor*** or ***manager*** did not adequately address his/her report or complaint, the ***employee*** may go directly to the ***Compliance Officer***, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. ***Members*** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or ***FWA*** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary

action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all ***Board members***, ***employees***, ***FDRs***, and ***members***. ***Members*** also have access to the ***Compliance Officer*** through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline directly.

3. *Report Directly to the Compliance Officer*

The ***Compliance Officer*** is available to receive reports of suspected or actual compliance violations, or ***FWA*** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from ***Board members***, ***employees***, ***FDRs*** and ***members***. The ***Compliance Officer*** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. ***FDRs*** are generally contractually obligated to report suspected ***fraud*** and ***abuse*** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or ***FWA***, issues in good faith. This non-retaliation policy extends to reports received from ***FDRs*** and ***members***. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the ***Compliance Officer*** will review and enforce disciplinary and/or other ***Corrective Action Plans*** for violations, as appropriate, with the approval of the ***Compliance Committee***.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board members, ***employees***, and ***FDRs*** are provided copies of CalOptima's ***Code of Conduct*** and the ***Compliance Plan*** and have access on CalOptima's internal and external website to applicable ***policies and procedures***, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing ***Corrective Action Plans*** and ***sanctions***. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board members, ***employees***, and ***FDRs*** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the ***Compliance Program*** documents and related ***policies and procedures***, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. ***Board members***, ***employees***, and ***FDRs*** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's ***Compliance Program*** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in ***Federal and/or State health care programs***;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, ***policies and procedures*** and/or contracts; or
- Failure to report violations or suspected violations of the ***Compliance Program***, or applicable laws, or to report suspected or actual ***FWA*** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates ***HIPAA*** and other privacy laws and/or CalOptima's ***HIPAA*** privacy and security policies, including actions that harm the privacy of ***members***, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the ***Compliance Program*** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, ***sanctions***, and/or termination, depending on the nature and severity of the conduct, or behavior. ***Board members*** may be subject to removal, ***employees*** are subject to discipline, up to and including termination, and ***FDRs*** may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative ***sanctions*** and/or penalties.

Further violations could lead to suspension, preclusion, or exclusion, from participation in ***Federal and/or State health care programs***.

CalOptima ***employees*** shall be evaluated annually based on their compliance with CalOptima's ***Compliance Program***. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, Audit & Oversight and ***Compliance Committee*** discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The ***Compliance Officer,*** or his/her ***designee,*** will collaborate with the ***Compliance Committee*** to identify areas of focus for monitoring and auditing potential non-compliant activity and ***FWA*** issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of ***FDRs***. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external ***audit*** and ***monitoring*** reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by ***CMS*** and the OIG Work Plan shall be used as resources to evaluate operational risks.

The ***Compliance Officer,*** or his/her ***designee,*** will work with the Chief Operating Officer, or his/her ***designee***, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject to more frequent monitoring and auditing, as well as additional reporting requirements. The risk assessment process will be managed by the ***Compliance Officer***, or his/her ***designee***, and presented to the ***AOC***, and subsequently to the ***Compliance Committee***, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused ***audits*** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine auditing and ***monitoring activities*** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima ***policies and procedures*** to protect against non-compliance and potential ***FWA*** in ***CalOptima programs***. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. ***Monitoring activities*** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An ***audit*** is 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. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer

service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The ***Compliance Officer***, or his/her ***designee,*** in collaboration with the ***AOC*** and ***Compliance Committee***, develops the monitoring and auditing work plans to address the risks associated with each of ***CalOptima's programs***.

The ***Compliance Officer,*** or his/her ***designee,*** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate auditing and ***monitoring activities***. ***Audits*** for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer, or his/her ***designee,*** will coordinate the ***audits*** with internal ***audit*** staff, and, in some cases, with the assistance from an outside vendor. ***Audit*** methodologies shall be consistent with regulatory and NCQA requirements and standards. All ***audits*** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the ***audit*** review is completed, the ***audit*** team will communicate the results to the ***Compliance Officer*** and propose follow up corrective action(s), if necessary. The ***Compliance Officer,*** or his/her ***designee,*** will provide reports to the CEO and the ***Compliance Committee*** concerning the results of the ***audits***. The ***AOC*** reports to the ***Compliance Officer*** and the ***Compliance Committee*** on ***audits*** that involve ***FDRs*** as discussed below. If ***FWA*** issues are identified during an ***audit***, the matter will be further investigated and resolved in a timely manner. In addition, an ***audit*** of the ***Compliance Program*** and its effectiveness should occur at least annually, and the results shall be reported to the ***CalOptima Board***.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to ***CMS***, ***DHCS***, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of ***FDRs*** who perform delegated activities. The processes that CalOptima implements to oversee, monitor, and ***audit FDRs*** are incorporated into CalOptima's written ***policies and procedures***, including processes involving pre-contractual evaluations and ***audits*** of ***First Tier Entities***. CalOptima may implement ***Corrective Action Plans***, ***sanctions***, and/or revoke its ***delegation*** of duties (in a manner permitted under the contract) if CalOptima determines that an ***FDR*** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The ***Compliance Officer***, or his/her ***designee***, determines the process for monitoring delegated ***FDRs*** and develops the annual monitoring and ***audit*** calendar in order to validate compliance with contractual standards and regulatory requirements. The ***AOC*** is responsible for overseeing all of the delegated activities and will review the readiness assessment, ensure the annual review of ***FDRs*** for delegated functions are completed, conduct formal on-going evaluation of ***FDR*** performance and compliance, ensure ***Downstream*** and ***Related Entities*** are monitored, and impose ***Corrective Action Plans*** and/or ***sanctions*** if the ***FDR***'s performance fails to meet statutory and contractual standards and requirements. The ***AOC*** may recommend termination of ***delegation*** to the ***Compliance Committee*** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or ***delegation*** agreement with a potential ***FDR***, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's ***policies and procedures***, is completed to determine the ability of the potential ***FDR*** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, ***CMS***, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not precluded on the Preclusion List, excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the ***DHCS*** Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the ***AOC*** and subsequently the ***Compliance Committee*** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the ***delegation*** agreement specifies the activities CalOptima delegates to the ***FDRs***, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and ***audits***, and remedies, including disciplinary actions, available to CalOptima. Prior to any ***sub-delegation*** to any ***Downstream*** or ***Related Entity***, a ***First Tier Entity*** must obtain approval from CalOptima. CalOptima determines who will directly monitor the ***Downstream*** or ***Related Entity***'s compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the ***FDR*** and their contractually delegated area(s). Furthermore, ***FDRs*** will be required to complete, sign, and return attestation forms confirming the ***FDR***'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and ***FWA*** as well as exclusion and preclusion screening and ***FWA*** reporting obligations.

3. *Annual Risk Assessment*

The ***Compliance Officer***, or his/her ***designee***, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the ***FDR***'s vulnerabilities and high-risk areas. High risk ***FDRs*** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any ***FDR*** deemed high risk, or vulnerable, is presented to the ***AOC*** for suggested follow-up ***audit***. ***FDRs*** determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from

FDRs, will be managed by the ***Compliance Officer***, or his/her ***designee***, and presented to the ***AOC*** and subsequently to the ***Compliance Committee*** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the ***FDR***'s ability to provide delegated services in accordance with contractual standards and applicable state, ***CMS***, and accreditation requirements, as further detailed in CalOptima's ***policies and procedures***. CalOptima may conduct ***audits*** of ***FDRs*** at any time. Such ***audits*** may include an evaluation of the ***FDR***'s training and education program and materials covering general compliance and ***FWA***, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk ***FDRs***, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual ***audit*** calendar; however, CalOptima does not limit its auditing schedule to only high-risk ***FDRs***.

If CalOptima has reason to believe the ***FDR***'s ability to perform a delegated function is compromised, an additional focused ***audit*** may be performed. The ***Compliance Officer,*** or his/her ***designee,*** may also recommend focused ***audits*** upon evaluation of non-compliant trends or reported incidents. The results of these ***audits*** will be reported to the ***AOC*** and then to the ***Compliance Committee***.

A focused ***audit*** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- Failure to comply with a ***Corrective Action Plan***;
- Reported or alleged ***fraud***, ***waste***, and/or ***abuse***;
- Significant policy variations that deviate from the CalOptima or state, ***CMS***, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to ***members*** (either suspected or reported);
- Sale, merger, or acquisition involving the ***FDR***;
- Significant changes in the management of the ***FDR***; and/or
- Changes in resources which impact CalOptima's and/or the ***FDR***'s operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The ***Compliance Officer,*** or his/her ***designee,*** shall submit regular reports of all monitoring, ***audit***, and corrective action activities to the ***Compliance Committee***. In instances where non-compliance is identified, a ***Corrective Action Plan*** shall be developed by the ***FDR*** and reviewed and approved by the ***Compliance Officer***, or his/her ***designee***. Every ***Corrective Action Plan*** is presented to the ***AOC*** for review. Supplemental and focused ***audits*** of ***FDRs***, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement ***sanctions*** or require remediation by an ***FDR*** for failure to fulfill contractual obligations including development and implementation of a ***Corrective Action Plan***. Failure to cooperate with CalOptima in any manner may result in termination of the ***delegation*** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including ***policies and procedures***, ***audit*** tools, and ***audit*** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated ***FDRs*** to monitor and track functions, performance, and ***audit*** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of ***audit*** tools;
- Implementation of a process for noticing ***FDRs*** and functional areas of ***Corrective Action Plans***;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding ***delegation*** standards, auditing, and monitoring ***FDR*** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of ***FDR*** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight ***audits*** completed within twelve (12) months; and
- ***Corrective Action Plans*** (***CAPs***) completed within the established timeframe.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's ***policies and procedures***, CalOptima performs ***Participation Status*** Reviews by reviewing the OIG –LEIE, the GSA–SAM, the ***DHCS*** Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure ***Board members***, ***employees***, and/or ***FDRs***

are not excluded, or do not become excluded or precluded from participating in ***Federal and/or State health care programs***. ***Board members***, ***employees***, and ***FDRs*** are required to disclose their ***participation status*** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when ***Board members***, ***employees***, and ***FDRs*** receive notice of a suspension, preclusion, exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its ***First Tier Entities*** comply with ***Participation Status*** Review requirements with respect to their relationships with ***Downstream Entities***, including without limitation, the delegated credentialing and re-credentialing processes.

The ***Compliance Officer,*** or his/her ***designee,*** will review reports from ***employees*** responsible for conducting the ***Participation Status*** Reviews to ensure ***employees*** record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the ***Compliance Officer*** of affirmative findings of a person, or entity's, failure to meet the ***Participation Status*** Review requirements. If CalOptima learns that any prospective, or current, ***Board member***, ***employee***, or ***FDR*** has been proposed for exclusion, excluded, or precluded, CalOptima will promptly remove him/her/the ***FDR*** from ***CalOptima's programs*** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies and/or contract terms. The ***Compliance Officer,*** or his/her ***designee,*** will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's ***Compliance Program*** and/or ***FWA*** issues, the ***Compliance Officer,*** or his/her ***designee,*** shall, upon promptly verifying the facts related to the violation or likely violation, notify the ***Compliance Committee***, as appropriate. The ***Compliance Committee*** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, ***sanctions***, termination of any agreement and/or any other corrective action (including repayment of ***overpayments***) consistent with applicable ***policies and procedures***, subject to consultation with legal counsel and/or notifying the ***Governing Body***, as appropriate;
- Implementing education and training programs for ***Board members***, ***employees***, and/or ***FDRs***, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's ***Compliance Plan***, ***Code of Conduct***, and/or relevant ***policies and procedures*** in an effort to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the ***Compliance Officer*** and the ***Compliance Committee*** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable ***policies and procedures*** after considering such recommendations. The ***Compliance Officer***, or his/her ***designee***, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to ***DHCS*** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning ***fraud*** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

activity indicates that ***fraud*** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a ***fraud*** alert is received, CalOptima shall review its ***delegation*** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the ***delegation*** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a ***fraud*** alert. With the issuance of a ***fraud*** alert, ***CMS*** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged ***fraud*** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, ***DHCS*** Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of ***Federal and/or State health care programs*** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., ***fraud*** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, ***DHCS***, ***CMS***, and ***CMS***' ***designee***, regarding monitoring of ***FDRs*** within CalOptima's network that ***DHCS***, or ***CMS***, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent ***FWA*** within a CalOptima program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of ***FWA*** activity. CalOptima shall assess all ***FDRs*** for potential ***overpayments*** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return ***overpayments*** consistent with applicable laws and regulatory guidance. Should revisions to reported data be required, CalOptima and/or FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of ***overpayment*** determinations to regulatory agencies, as required by law.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of ***FWA*** are components of CalOptima's ***Compliance Program***. ***FWA*** activities are implemented and overseen by CalOptima's ***Compliance Officer,*** or his/her ***designee,*** in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for ***FWA*** investigations. The ***Compliance Officer,*** or his/her ***designee,*** reports ***FWA*** activities to the CalOptima ***Compliance Committee***, CEO, the ***CalOptima Board***, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent, and remediate ***FWA***. In addition, CalOptima promptly investigates suspected ***FWA*** issues and implements disciplinary, or corrective, action to avoid recurrence of ***FWA*** issues. The objective of the ***FWA*** program is to ensure that the scope of benefits covered by the ***CalOptima programs*** is appropriately delivered to ***members*** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify ***FWA*** and promptly respond appropriately to such incidents of ***FWA***.

I.TRAINING

As detailed above, ***FWA*** training is provided to all ***Board members*** and ***employees*** as part of the overall compliance training courses in order to help detect, prevent, and remediate ***FWA***. ***FDRs*** are also required to complete ***FWA*** training, as described above. CalOptima's ***FWA*** training provides guidance to ***Board members***, ***employees***, and ***FDRs*** on how to identify activities and behaviors that would constitute ***FWA*** and how to report suspected, or actual, ***FWA*** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual ***FWA***;
- Examples of the most common types of member ***FWA*** (see Appendix B, attached hereto and incorporated herein) and ***FDR FWA*** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify ***FWA*** in ***CalOptima programs*** (*e.g.,* suspicious activities suggesting CalOptima members, or their family ***members***, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the ***CalOptima programs***, etc.);
- Information on how to identify potential prescription drug ***FWA*** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential ***FWA*** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for ***FDRs***, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the ***False Claims Act*** and CalOptima's requirement to train ***employees*** and ***FDR***s on the ***False Claims Act*** and other applicable ***FWA*** laws.

CalOptima shall provide ***Board members***, ***employees***, ***FDRs***, and ***members*** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of ***FWA***. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. ***Members***, ***FDRs***, ***employees***, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect ***FWA*** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record ***audits***;
- ***Member*** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and ***monitoring activities***;
- Monitoring external health care ***FWA*** cases and determining if CalOptima's ***FWA*** Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and ***audits***.

b. Data Analytics

CalOptima uses technology and data analysis to reduce ***FWA*** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect ***FDRs*** based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that Federal and State funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of ***FWA***.

The following trends will be reviewed and flagged for potential ***FWA***, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by ***members*** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or

- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected ***FWA***. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a ***member*** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of ***FWA***. The presence of several indicators may suggest ***FWA***, but further investigation is needed to determine if a suspicion of ***FWA*** actually exists. The following list below highlights common industry indicators and red flags that are used to determine whether or not to investigate an ***FDR*** or their claim disposition:

- Claims that show any altered information (dates; codes; names).

- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the ***member***/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the ***FWA*** database and a report is generated and submitted to the ***Compliance Officer***, ***Compliance Committee***, and CEO.

III.INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected ***FWA*** or detects ***FWA*** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an ***FDR*** to obtain relevant information;
- SIU, or a ***designee***, interviews the individual who reported the ***FWA***, affected ***members*** and/or ***FDRs***, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of ***FDR*** enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;

- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the ***Compliance Officer*** and ***Compliance Committee*** for discussion and approval.

IV.FINDINGS, RESPONSE, AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of ***FWA***, need for contract amendment, education and training requirement, recommendation of focused ***audits***, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential ***FWA*** issue has been identified, the SIU will track and trend the ***FWA*** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the ***Compliance Committee*** on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's ***policies and procedures***, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima ***policies and procedures***, CalOptima shall take appropriate disciplinary, or corrective, action against ***Board members***, ***employees***, and/or ***FDRs*** related to validated instances of ***FWA***. CalOptima will also assess ***FDRs*** for potential ***overpayments*** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the ***Compliance Committee***, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial ***sanctions***, regulatory reporting, ***Corrective Action Plans***, or termination of the ***delegation*** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first ***Compliance Committee*** following the date of identification of the suspected ***FWA***, the date of report to ***DHCS***, or the date of ***FWA*** substantiation by ***DHCS*** subsequent to the report. If vulnerability is identified through a single ***FWA*** incident, the correction action may be applied universally.

V.REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential ***FWA*** to appropriate regulatory agencies, or their designated program integrity contractors, including the ***CMS*** MEDIC, ***DHCS*** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. ***FDRs*** shall report ***FWA*** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected ***FWA***, should be reported to ***CMS*** and/or ***DHCS***, as soon as possible after discovery, but no later than ten (10) working days to ***DHCS*** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect, or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of ***FWA***;
- Patterns of ***FWA*** threatening the life, or well-being, of CalOptima ***members***; and/or
- Schemes with large financial risk to CalOptima, or its ***members***.

VI.ANNUAL EVALUATION

CalOptima's ***Compliance Committee*** shall periodically review and evaluate the ***FWA*** activities and its effectiveness as part of the overall ***Compliance Program audit*** and ***monitoring activities***. Revisions should be made based on industry changes, trends in ***FWA*** activities (locally and nationally), the OIG Work Plan, the CalOptima ***Compliance Plan***, and other input from applicable sources.

VII.RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of ***FWA*** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of ***FWA*** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII.CONFIDENTIALITY

CalOptima and its ***FDRs*** shall maintain all information associated with suspected, or actual, ***FWA*** in confidential files, which may only be released in accordance with applicable laws and CalOptima ***policies and procedures***. All participants and attendees of CalOptima's Quality Improvement Committee, ***Compliance Committee***, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the ***Compliance Program***, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the ***Compliance Program*** against the elements of an effective ***Compliance Program*** as recommended by OIG and required by ***CMS*** regulations. The following areas will be reviewed:

- ***Policies and procedures***;
- ***Compliance Officer*** and ***Compliance Committee***;
- Training and education of ***Board members***, ***employees***, and ***FDRs***;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing;
- ***Delegation*** oversight;
- Exclusion and preclusion screening process; and
- Prompt responses to detected offenses.

The ***Compliance Program*** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with ***senior management***, the ***Compliance Committee***, and the ***CalOptima Board***. Updates to the ***Compliance Program*** will be based on the results of the evaluation and will be referred to the ***CalOptima Board*** for review and approval.

I.FILING SYSTEMS

The ***Compliance Officer,*** or his/her ***designee,*** shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

a. Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- ***Compliance Plan*** and any amendments;
- Any ***Compliance Program policies and procedures*** issued after the initiation of the ***Compliance Program***;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, ***Compliance Plan***, ***Code of Conduct*** and/or appointment of the ***Compliance Officer***;
- All non-privileged communications to the ***Compliance Officer*** (original);
- All ***Compliance Committee*** and ***CalOptima Board*** minutes in which compliance issues are discussed; and/or
- Any other written records of the ***AOC***, or other oversight activities (originals if generated by the ***Compliance Officer***).

b. Information and Education File

This file shall contain copies of the following (unless originals specified):

- ***FDR*** training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- ***Board member*** and ***employee*** training records, attestations, and attendance records are maintained by the Human Resources Department.
- Educational materials provided to ***Board members***, ***employees***, and ***FDRs***;
- Notices, ***fraud*** alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

c. Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to compliance reports including reports to the Compliance and Ethics Hotline

and/or to the ***Compliance Officer*** (originals);

- Records relating to periodic monitoring and auditing of the ***Compliance Program*** (originals);
- Records relating to ***Board member***, ***employee***, and ***FDR Participation Status*** Review or background checks (originals except where ***FDRs*** perform ***Participation Status*** Reviews);
- Records relating to established periodic monitoring mechanisms;
- All documents pertaining to the enforcement of the ***Compliance Program***, including, investigations and disciplinary and/or corrective actions; and/or
- All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

d. Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the ***Compliance Officer***, legal counsel, and the ***Compliance Committee***, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the ***Compliance Officer***;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning ***FDR delegation*** agreement interpretations and remedies available to CalOptima.

e. Document Retention

All of the documents to be maintained in the filing system described above shall be retained for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by ***HIPAA*** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) ***policies and procedures*** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by ***HIPAA***; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under ***HIPAA***; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** 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 CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss employee and contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Principle	Standard
	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

Principle	Standard
	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its health networks and third party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.
Public Integrity	**Public Records**

Principle	Standard
CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files**

Principle	Standard
	Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

Principle	Standard
	Third-Party Sponsored Events CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, and gender expression), sexual orientation, health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and health networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its health networks, physician groups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all employees, contractors, health networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for

Principle	Standard
	failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by health networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima
AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.
I attended the annual Compliance Training Session on _____.

_____
Print Name

_____
Signature

_____
Date

RETURN TO THE COMPLIANCE OFFICER

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means 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 (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director 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.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare

program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the

Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is 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 ("Downstream Entity") means 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 or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means 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.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means 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.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Overpayment ("Overpayment") means a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its health networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State health care programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means 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 ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or

its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Senior Management ("Senior Management") means any employee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Attachment 3: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

Department	Policy #	Policy Title	Summary of Change(s)	Reason for Change(s)
Audit & Oversight – External	**GG.1605**	Delegation and Oversight of Credentialing and Recredentialing Activities	▪ Aligned the Credentialing and Recredentialing file review tool procedure to operational changes, including: • Removal of the 8/30 methodology; • Using a targeted approach or select files with potential issue(s) of non-compliance; and • Selecting, at minimum, 5% or 50 files (whichever is less) to ensure that all information is appropriately verified. ▪ Clarified the roles of the Audit & Oversight Committee and the Compliance Committee.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations
Audit & Oversight – External	**GG.1619**	Delegation Oversight	▪ Added focus areas for readiness assessment(s), annual audit(s), focused and ad hoc review(s), and ongoing monitoring of delegated entities. ▪ These areas of focus now include: • Sub-contractual; • Marketing; • Provider Network Contracting; • Provider Relations; • Translation Services; • Insurance; • Medi-Cal Addendum(s); • Member Connections; and • Whole Child Model.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations

Department	Policy #	Policy Title	Summary of Change(s)	Reason for Change(s)
Audit & Oversight - External	**HH.2027**	Annual Risk Assessment (Delegate)	▪ Emphasized CalOptima's responsibility to the contract with CMS and DHCS and fulfilling the requirement of establishing and implementing an effective system of routine monitoring and identification of compliance risks. ▪ Clarified the FTE's responsibility to conduct risk assessments and ongoing monitoring and audit of downstream entities with which they contract to ensure compliance.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations
Audit & Oversight - External	**HH.4001Δ**	Audit & Oversight Committee	▪ Added the Director, Audit & Oversight (Internal) as a chair of the AOC. ▪ Removed 'pre-delegation' terminology throughout the policy. ▪ Updated Glossary with applicable terms and definitions.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations
Privacy	**HH.3001Δ**	Member Access to Designated Record Set	▪ Clearly explained the thirty (30) calendar day extension of DRS access requests. ▪ Incorporated language describing additional circumstances under which the Office of Compliance may deny a member access to the DRS, such as: • PHI that is not used to make decisions about members • A CalOptima PACE covered health care provider may deny an inmate's request to obtain a copy of PHI • PHI created or obtained by a CalOptima PACE covered health care provider in the course of research • For OneCare Connect, a member's access to PHI that is contained in records subject to the Privacy Act, 5, USC, §552a.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations

Department	Policy #	Policy Title	Summary of Change(s)	Reason for Change(s)
Privacy	**HH.3003Δ**	Verification of Identity for Disclosure of Protected Health Information	▪ Clarified written requests for copies of a minor's PHI, stating that valid legal documentation demonstrating the requestor is the minor's personal representative is required. ▪ Added language speaking to the sharing of PHI to avert serious threat to health or safety of a member, so long as the disclosure is consistent with applicable law and standards of ethical conduct.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations
Privacy	**HH.3005Δ**	Member Request for Accounting of Disclosures	▪ Incorporated language for the disclosures excluded from accounting to include the facility's directory, provided in Title 45, CFR, §164.510 with respect to PACE. ▪ Clarified the requirements for accounting of disclosures to a member. ▪ Outlined the extension period CalOptima may request and its limitations.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations
Privacy	**HH.3011Δ**	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	▪ Added language stating CalOptima may only use mental health treatment PHI for its own treatment purposes. ▪ Emphasized that the minimum necessary rule applies to uses and disclosures for health care operations.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations
Privacy	**HH.3020Δ**	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI, or Other Unauthorized Use or Disclosure of PHI/PI	▪ Incorporated language stating CalOptima management shall issue corrective action to employees responsible for intentional or negligent actions resulting in unauthorized access to PHI/PI. ▪ Clarified notification requirements with regard to electronic mail, major print, or broadcast media. ▪ Included language with regard to law enforcement official requests to delay notification due to impediment of a criminal investigation or damage to national security.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations

Department	Policy #	Policy Title	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	**HH.2014Δ**	Compliance Program	▪ Added the 2019 Compliance Plan and FDR Compliance Attestation as attachments.	Annual review to incorporate revisions to align with the 2019 Compliance Plan and current operations

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive changes for the CalOptima Office of Compliance, by department.

Department	Policy #	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight – External	**HH.2015**	Health Network Claims Processing	▪ No substantive changes made since the 2017 annual review.	N/A
Audit & Oversight – External	**HH.2025**	Health Network Subdelegation and Subcontracting	▪ No substantive changes made since the 2017 annual review.	N/A
Audit & Oversight – External	**HH.2026**	Claims Delegation and Oversight	▪ No substantive changes made since the 2017 annual review.	N/A
Audit & Oversight - Internal	**HH.4002**	CalOptima Internal Oversight	▪ No substantive changes made since the 2017 annual review.	N/A
Audit & Oversight - Internal	**HH.4003**	Annual Risk Assessment	▪ No substantive changes made since the 2017 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.1105Δ**	Fraud, Waste, and Abuse Detection	▪ No substantive changes made since the 2017 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.1107Δ**	Fraud, Waste, and Abuse Investigation and Reporting	▪ No substantive changes made since the 2017 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.5000Δ**	Provider Overpayment Investigation and Determination	▪ No substantive changes made since the 2017 annual review.	N/A
Fraud, Waste, Abuse – Special Investigations Unit	**HH.5004Δ**	False Claims Act Education	▪ No substantive changes made since 08/02/18 Board of Directors Approval	N/A
Privacy	**HH.3000Δ**	Notice of Privacy Practices	▪ No substantive changes made since the 2017 annual review.	N/A

Department	Policy #	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	**HH.3002Δ**	Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3004Δ**	Member Request to Amend Records	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3006Δ**	Tracking and Reporting Disclosures of Protected Health Information (PHI)	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3007Δ**	Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3008Δ**	Member Right to Request Confidential Communications	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3009Δ**	Access by Member's Authorized Representative	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3010Δ**	Protected Health Information (PHI) Disclosures Required by Law	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3014Δ**	Use of Electronic Mail with Protected Health Information (PHI)	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3015Δ**	Member Authorization for the Use and Disclosure of Protected Health Information (PHI)	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3016Δ**	Guidelines for Handling Protected Health Information (PHI) Offsite	▪ No substantive changes made since the 2017 annual review.	N/A
Privacy	**HH.3019Δ**	De-identification of Protected Health Information (PHI)	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2002Δ**	Sanctions	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2005Δ**	Corrective Action Plan	▪ No substantive changes made since 08/02/18 Board of Directors Approval	N/A
Regulatory Affairs & Compliance	**HH.2007Δ**	Compliance Committee	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2018Δ**	Compliance and Ethics Hotline	▪ No substantive changes made since the 2017 annual review.	N/A

Department	Policy #	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	**HH.2019Δ**	Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Policies	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2020Δ**	Conducting Compliance Investigations	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2021Δ**	Exclusion Monitoring	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2022Δ**	Record Retention and Access	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2023Δ**	Compliance Training	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2028Δ**	Code of Conduct	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.2029Δ**	Annual Compliance Program Effectiveness Audit	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**HH.3012Δ**	Non-Retaliation for Reporting Violations	▪ No substantive changes made since the 2017 annual review.	N/A
Regulatory Affairs & Compliance	**MA.9124**	CMS Self-Disclosure	▪ No substantive changes made since the 2017 annual review.	N/A

Policy #:	GG.1605
Title:	**Delegation and Oversight of Credentialing and Recredentialing Activities**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	12/95
Last Review Date:	~~12/07/17~~1
Last Revised Date:	2/06/18
	~~12/07/17~~1
	2/06/18
Applicable to:	☒ Medi-Cal
	☒ OneCare
	☒ OneCare Connect

~~*Board Approved Policy*~~

I. PURPOSE

This policy outlines the processes by which CalOptima shall ensure Credentialing and Recredentialing activities are performed by Delegated Entities in accordance with quality, state, and federal standards.

II. POLICY

A. CalOptima may delegate Credentialing and Recredentialing of a Practitioner to a Delegated Entity, in accordance with this policy.

B. CalOptima shall comply with California rules of Delegation of Quality Improvement Activities, in accordance with Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E), including continuous review of the quality of care provided.

C. CalOptima's quality assurance program shall be designed to ensure that:

1. Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to CalOptima providers, and/or others; and

2. CalOptima does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

D. CalOptima shall comply with Title 42, Code of Federal Regulations, Section 438.230(b), the Medicaid managed care regulation governing delegation and oversight, and the Medicare Managed Care Manual, Chapter, 11, Section 110.2.

E. CalOptima shall remain accountable for Credentialing and Recredentialing of its Practitioners, even if CalOptima delegates all or part of these activities.

1. Delegated activities may include, but are not limited to, processing credentialing applications, credentialing decision-making, development of decision-making criteria, credentialing policies and procedures, credentialing verification, credentialing file management, and monitoring of sanctions and exclusions.

F. CalOptima shall be responsible to perform a ~~pre-delegation~~ Readiness Assessment before implementing Delegation. This assessment will include verification that the Delegated Entity has devoted sufficient resources and appropriately qualified staff to perform the functions. The following shall be mutually agreed upon between CalOptima and the delegated party:

1. A written Delegation Acknowledgment and Acceptance Agreement Document (hereafter Delegation Agreement) describing all the delegated Credentialing activities; and

2. CalOptima shall retain the right to approve, suspend, and terminate individual Practitioners, providers, and sites in situations where CalOptima has delegated decision making, as addressed in the ~~delegation agreement.~~Delegation Agreement. CalOptima shall not sub-delegate Peer Review Body functions and the determination of a Practitioner's participation in the CalOptima program.

~~3.~~G. CalOptima shall monitor the performance of a ~~delegated entity~~Delegated Entity on an ongoing basis.

~~G.~~H. On an annual basis, CalOptima shall perform an audit of Credentialing written policies and procedures as well as a review of Credentialing files.

~~H.~~I. On a monthly basis, CalOptima shall evaluate required reports as agreed upon in the Delegation Agreement. CalOptima shall conduct a monthly Credentialing and Recredentialing file review, unless otherwise specified.

~~I.~~J. CalOptima shall identify and follow-up on opportunities for improvement, if applicable.

~~J.~~K. CalOptima shall require a Delegated Entity to respond to a Corrective Action Plan (CAP), based on any deficiency or area of non-compliance determined during the ~~pre-delegation~~ Readiness Assessment, monthly file review, or annual audit~~.~~ in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. Subject to CalOptima's approval of the delegated Credentialing and Recredentialing activities, the written Delegation Agreement shall include the following:

1. Mutual agreement demonstrated by signatures from both CalOptima and the Delegated Entity, and a description of:

a. Delegated activities;

b. CalOptima and the Delegated Entity responsibilities, which at a minimum include:

i. Acceptance of applications, reapplications, and attestations;

ii. Collection of all data elements from the National Committee for Quality Assurance (NCQA) or other appropriate sources, in accordance with CalOptima Policies;

iii. Collection and evaluation of ongoing monitoring information; and

iv. Decision-making in respect to oversight of Credentialing activities.

c. Reporting responsibilities and reporting frequency, which shall indicate a minimum of monthly reporting, unless specified otherwise. The reporting responsibilities shall be noted on the Timely and Appropriate Submissions Grid~~,~~., and include~~:~~

i. A list of Credentialed, Recredentialed, and Terminated Practitioners submitted monthly to CalOptima;

d. The process by which CalOptima evaluates the Delegated Entity's performance, which includes:

i. ~~Pre Delegation~~ Readiness Assessment;

ii. Monthly file review;

iii. Annual audit; and

iv. Reporting.

e. Remedies available to CalOptima if the Delegated Entity does not fulfill its obligations, including revocation of the Delegation Agreement, and Sanctions as referenced in CalOptima Policy HH.2002Δ: Sanctions;

f. CalOptima's right to approve, suspend and terminate individual Practitioners, providers, and sites in situations where CalOptima has delegated decision-making; and

g. CalOptima's right to reject a Practitioner upon reason that the Practitioner has failed to meet the Credentialing or Recredentialing requirements, as outlined in the Delegation Agreement and CalOptima Policies.

B. ~~Pre Delegation~~ Readiness Assessment

1. CalOptima shall conduct a ~~pre-delegation~~ Readiness Assessment of a Delegated Entity to determine the Delegated Entity's ability to implement delegated Credentialing and Recredentialing activities before entering into and implementing a Delegation Agreement.

2. The ~~pre-delegation~~ Readiness Assessment shall consist of a comprehensive desk review and on-site evaluation, utilizing the delegation oversight audit tool, which will evaluate a Delegated

Entity's capacity to provide all delegated functions. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit. The evaluation shall include:

a. Written review of the Delegated Entity's understanding of applicable standards;

b. Delegated tasks;

c. Review of policies and procedures;

d. Staffing capabilities;

e. Performance records;

f. Review of Credentialing system; and

g. Credentialing and Recredentialing ~~File~~file review.

3. Upon completion of the ~~pre-delegation~~ Readiness Assessment, CalOptima's Director of Audit & Oversight shall report the ~~pre-delegation~~ Readiness Assessment results to the Audit & Oversight Committee (AOC) meeting.

4. The AOC shall determine if the Delegated Entity meets CalOptima's criteria for Delegation of Credentialing and Recredentialing activities based on the results of the ~~pre-delegation~~ Readiness Assessment.

a. If the AOC determines that a Delegated Entity does not meet CalOptima's criteria for Delegation of Credentialing and Recredentialing activities, CalOptima may reassess such Delegated Entity no earlier than three (3) months after the initial ~~pre-delegation~~ Readiness Assessment.

C. Delegated Entity Responsibilities

1. A Delegated Entity shall:

a. Develop and implement processes, in accordance with this policy, for the Credentialing and Recredentialing of Practitioners with whom it contracts or employs;

b. Develop policies and procedures that:

i. Are consistent with this policy, and specify:

a) Types of Practitioners covered;

b) Criteria for Credentialing and Recredentialing; and

c) Verification sources used~~; and~~.

ii. Address the following:

a) The process to delegate Credentialing or Recredentialing activities;

b) The process used to ensure that Credentialing and Recredentialing are conducted in a non-discriminatory manner;

c) The process for written notification to a Practitioner of any information obtained during the Delegated Entity's Credentialing process that varies substantially from the information provided by the Practitioner;

d) The process to ensure that Practitioners are notified of the Credentialing or Recredentialing decision within sixty (60) calendar days after the decision.

e) The medical director or other designated physician's direct responsibility and participation in the Credentialing program;

f) The process used to ensure the confidentiality of all information obtained in the Credentialing process, except as otherwise provided by law; and

g) The process for making Credentialing and Recredentialing decisions~~; and~~.

iii. Include the Practitioner's right to:

a) Review information submitted to support his or her Credentialing application;

b) Correct erroneous information;

c) Request information on the status of his or her Credentialing or Recredentialing application; and

d) Receive notification of these rights~~; and~~.

iv. Address ongoing monitoring of:

a) Medicare and Medicaid Sanctions;

b) State sanctions or limitations on licensure; and

c) Complaints and grievances.

c. Develop policies and procedures to verify the participation status of the Delegated Entity's agents to ensure that they shall:

i. Immediately disclose to CalOptima's Audit ~~and~~& Oversight Department any pending investigation involving, or any determination of, suspension, exclusion, or debarment by the Delegated Entity or its agents, occurring or discovered during the term of the Contract for Health Care Services; and

ii. Take immediate action to remove any Delegated Entity agent ~~that~~who does not meet participation status requirements from furnishing items or services related to the Health Network Service Agreement (whether medical or administrative) to Members.

d. Designate dedicated staff responsible for the timely Credentialing and Recredentialing of all Practitioners~~; and~~.

e. Credential and recredential Practitioners, in accordance with CalOptima Policies.

D. Sub-Delegation

1. A Delegated Entity shall not delegate any Credentialing or Recredentialing activity without prior written approval from CalOptima.

2. If a Delegated Entity delegates to a credentialing verification organization (CVO), CalOptima requires that the CVO be certified by NCQA. ~~-~~The Delegated Entity shall retain ultimate responsibility for any delegated activities.

3. Prior to delegating Credentialing activities, Delegated Entity shall evaluate the potential Sub-Delegate's capacity to perform such activities, according to CalOptima Credentialing and Recredentialing standards.

4. The delegated activities shall be described in a written Delegation Agreement with the Sub-Delegate. The agreement between the Delegated Entity and a Sub-Delegate shall include all of the following:

a. The responsibilities of each party;

b. The delegated activities;

c. The process by which a Delegated Entity shall evaluate the Sub-Delegate's performance;

d. The remedies, including revocation of D~~d~~elegation, available to the Delegated Entity if the Sub-Delegate does not fulfill its obligations;

e. A process for submission of regular reports by the Sub-Delegate to the Delegated Entity;

f. The Delegated Entity shall provide ongoing monitoring of the Sub-Delegate's activities under the agreement;

g. Both CalOptima and the Delegated Entity's Peer Review Body shall retain the right to approve, terminate or suspend individual practitioners, providers or sites based upon quality issues;

h. Agreement as to the exchange of information between the Delegated Entity and the Sub-Delegate, including a definition of peer review or confidential information, and a process for sharing information with each other and with third parties;

i. A process for handling Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended; and

j. A monitoring and auditing schedule.

5. A Delegated Entity shall be responsible for providing oversight for all delegated Credentialing activities.

6. ~~On an annual basis~~At least annually, Delegated Entity shall evaluate the Sub-Delegate's Credentialing process. The evaluation shall ensure that the delegated activities are conducted in accordance with CalOptima's Credentialing standards.

7. The Delegated Entity shall submit to CalOptima an annual report documenting the Delegated Entity's evaluation process of the delegated function.

8. CalOptima shall monitor the Delegated Entity's oversight process of the Sub-Delegate through CalOptima's annual oversight of the Delegated Entity's Credentialing and Recredentialing process.

E. Annual Audit

1. ~~On an annual basis~~At least annually, CalOptima shall perform an audit of written policies and procedures as well as a review of Credentialing files to ensure compliance with ~~the National Committee for Quality Assurance (NCQA)~~all applicable NCQA, regulatory and contractual standards for each year that the D~~d~~elegation is in effect. The annual audit shall be based on the responsibilities stated in the Delegation Agreement and performance of delegated activities, as well as the appropriate NCQA, regulatory and contractual standards. This audit may be performed on-site -and/or via desktop review. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit.

2. The annual audit shall include the review of policies and procedures utilizing the delegation oversight annual audit tool. This audit will include, but not be limited to:

a. A review of Delegated Entity's Peer Review Body meeting minutes, which shall be conducted for Credentialing and Recredentialing activities;

b. A review to confirm the Delegated Entity's reporting procedure to CalOptima when there is action taken against a practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG), or the National Practitioner Data Bank (NPDB).)

3. An annual file review is also conducted utilizing the Credentialing and Recredentialing file review tool:

a. CalOptima shall apply ~~the 8/30 methodology~~a targeted approach or select files with potential issue(s) of non-compliance when conducting the annual file review~~. CalOptima will select a random sample of thirty (30) Credentialing and thirty (30) Recredentialing files~~, and will provide the organization with the file selection.

i. ~~Eight (8)~~The number of files selected for each file type will ~~be randomly chosen for~~ vary depending on the audit area, its associated risk level, and/or the ~~initial review.~~number of files available. Credentialing requirements applicable to both file types are scored for all files.

~~i.~~ii. At a minimum, CalOptima will select five (5) percent or fifty (50) files, whichever is less, to ensure that information is verified appropriately. The sample must include at least ten (10) Credentialing files and ten (10) Recredentialing files. If fewer than ten (10) Practitioners were credentialed or recredentialed since the last annual audit, CalOptima ~~shall review files until it has sufficient results to score based on the 8/30 methodology~~audits the universe of files rather than a sample.

b. If the requirement applies only to initial Credentialing files (e.g., work history) or to Recredentialing files (e.g., Recredentialing cycle length), the requirement is scored 'Not Applicable' for the file type that does not apply. ~~CalOptima shall score only applicable files until it has sufficient results to score based on its 8/30 methodology.~~

~~i. If fewer than thirty (30) Practitioners were Credentialed or Recredentialed within the look back period, CalOptima shall audit the universe of files rather than a sample.~~

c. CalOptima shall review documentation of substantive evaluation and action plans, if needed.

d. If the Delegated Entity does not have any files for Credentialing or Recredentialing between audit cycles, CalOptima will not perform an annual audit, but instead shall require the Delegated Entity to meet all other delegation oversight requirements, and provide documentation that the Delegated Entity did not Credential or Recredential Practitioners between audit cycles.

4. Based on the results of the annual audit, CalOptima may take the following actions:

a. Require a Delegated Entity to respond to and submit a CAP addressing all areas of deficiency as determined by CalOptima in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan;

b. Audit the Delegated Entity's implementation and completion of an approved CAP, and any performance area(s) addressed in the CAP;

c. Impose Sanctions against a Delegated Entity, in accordance with CalOptima Policy HH.2002Δ: Sanctions;

d. Initiate the de-delegation process in accordance with Section III.F of this policy.

5. ~~CalOptima staff shall report~~Annual audit findings ~~from oversight reviews~~ and CAPs ~~will be~~ reported by the Audit & Oversight Department to the AOC with recommendations for follow-up activities~~.~~ and subsequently to the Compliance Committee for approval.

F. ~~F.~~ De-Delegation

1. The Audit & Oversight Credentialing Auditor shall review CAPs that do not meet the compliance threshold or are classified as '~~delinquent,~~'deficient' and shall make appropriate recommendations to the AOC.

2. The AOC shall review a Delegated Entity's Delegation status based on the CAP timeline and level of achievement.

3. If a Delegated Entity fails to achieve compliance within the timeframes set forth in the CAP, the AOC may recommend de-delegation of Credentialing and Recredentialing.

4. If the AOC recommends de-delegation of Credentialing and Recredentialing activities from the Delegated Entity, and Compliance Committee approves the recommendation, CalOptima shall:

   a. Provide the Delegated Entity with thirty (30) calendar days written notice of CalOptima's intent to de-delegate;

   b. Inform Practitioners of the de-delegation and instructions for continued services;

   c. Adjust the Delegated Entity's payments, as appropriate, to the de-delegated status of Credentialing and ~~Re-credentialing~~Recredentialing activities; ~~and~~

   d. Prepare appropriate CalOptima departments to perform the de-delegated Credentialing and Recredentialing activities; and

   e. CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

5. A Delegated Entity shall cooperate with CalOptima to ensure a smooth transition and continuous care for Members during the de-delegation transition period.

6. CalOptima may re-evaluate a Delegated Entity's ability to perform delegated Credentialing and Recredentialing activities no sooner than twelve (12) months after de-delegation.

   a. CalOptima shall utilize the ~~pre-delegation~~ Readiness Assessment process, as described in Section III.B of this policy.

   b. CalOptima shall delegate Credentialing and Recredentialing activities to Delegated Entity based on the ~~pre-delegation~~ Readiness Assessment results.

   c. The Director of Audit & Oversight shall present the re-audit ~~pre-delegation~~ Readiness Assessment to the AOC.

d. If the AOC recommends approval of ~~Delegation~~delegation of Credentialing and Recredentialing activities to the Delegated Entity, and the Compliance Committee approves the recommendation, CalOptima shall re-delegate such activities, and adjust the Delegated Entity's payment accordingly.

e. If the AOC recommends denial of re-delegation of Credentialing and Recredentialing activities to the Delegated Entity, it may also recommend additional Sanctions on the Delegated Entity, up to and including termination of the Contract for Health Care Services, to the Compliance Committee for final action~~.~~ and if the Compliance Committee concurs, CalOptima will not re-establish the Delegation of Credentialing and Recredentialing activities to the Delegated Entity.

7. CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

H. Exchange of Information

1. CalOptima may, at its discretion, share copies of a report received from a Delegated Entity regarding an adverse action, if CalOptima deems that such report may protect the medical care of a Member.

a. Such reports may include, but are not limited to, action taken against a Practitioner that relates to professional behavior or clinical competence, suspensions, terminations, legal actions, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG) or the National Practitioner Data Bank (NPDB)).

b. The provision of any such report to another Delegated Entity shall not relieve the Delegated Entity of an independent duty to comply with Credentialing procedures or to query or file a report with state or federal regulatory agencies.

2. CalOptima retains the right to review all components of a Delegated Entity's file.

I. Monitoring

1. CalOptima shall monitor a Delegated Entity's Credentialing and Recredentialing activities through reports, monthly file reviews, and continuous improvement activities.

~~a. Monthly Credentialing Universe~~

~~i. The Monthly Credentialing Universe is due to CalOptima on the second (2nd) day of every month.~~

~~a) Universes must be submitted via FTP server to the 'HN_Reporting' folder utilizing the instructed naming conventions. Effective January 1, 2016, a single universe template will be utilized for reporting all contracted lines of business.~~

~~b.~~a. Monthly File Review

i. On a monthly basis, CalOptima will review Credentialing and Recredentialing files for each delegate. ~~Delegates that are NCQA-Certified or Accredited are exempt from the Monthly File Review, but are still required to submit Monthly Credentialing Universes.~~

a) ~~The~~ CalOptima ~~auditor will~~ shall apply a targeted approach or select files with potential issue(s) of non-compliance when conducting the ~~following~~monthly file ~~types at random from~~review.

~~a)~~1. The number of files selected for each file type will vary depending on the ~~Monthly Credentialing Universe submitted:~~monitoring activity, its associated risk level, and/or the number of files available.

~~1. Eight (8) Credentialing Files; and~~

2. ~~Eight (8) Recredentialing Files.~~At a minimum, CalOptima will select five (5) percent or fifty (50) files, whichever is less, to ensure that information is verified appropriately. The sample must include at least ten (10) credentialing files and ten (10) Recredentialing files. If fewer than ten (10) Practitioners were credentialed or recredentialed since the last monthly file review, CalOptima reviews the universe of files rather than a sample.

ii. The CalOptima auditor will notify the Delegated Entity via email of the file selection no later than the fourth (4th) of every month.

iii. The Delegated Entity shall submit the selected Credentialing and Recredentialing files to CalOptima on the tenth (10th) of every month.

a) Credentialing and Recredentialing files must be submitted via FTP server into the 'HN_Reporting' folder utilizing the instructed naming ~~conventions~~convention.

b. Monthly Credentialing Universe

i. Delegates that are NCQA-Certified or Accredited are exempt from the monthly file review, but are still required to submit monthly Credentialing universes.

ii. The monthly Credentialing universe is due to CalOptima on the second (2nd) day of every month.

a) Universes must be submitted via FTP server to the 'HN_Reporting' folder utilizing the instructed naming convention. Effective January 1, 2016, a single universe template will be utilized for reporting all contracted lines of business.

2. A Delegated Entity shall submit reports to CalOptima on a periodic basis, as specified by CalOptima on the Timely and Appropriate Submissions Grid, including, but not limited to, those reports based on the mutually agreed- upon Delegation Agreement:

a. Reports shall include, but are not limited to:

i. Monthly Credentialing and Recredentialing reports;

ii. A list of all active Practitioners on an annual basis;

iii. Verification of Board Certification for Practitioners who claim Board Certification status; and

iv. Annual reports of any Sub-Delegate's performance, if CalOptima approved such S~~s~~ub-D~~d~~elegation.

b. A Delegated Entity shall ~~submit such reports to CalOptima in accordance with the Delegation Agreement~~also:

~~i. CalOptima shall require a Delegated Entity:~~

~~a)~~i. ~~To notify~~Notify CalOptima immediately of any investigation by a regulatory or licensing agency of a Practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., ~~Medical Board of California (MBOC), Office of the Inspector General (OIG)) or the National Practitioner Data Bank (NPDB)).~~MBOC, OIG, NPDB); and

~~b)~~ii. ~~To provide~~Provide CalOptima copies of any California Business and Professions Code, Section 805 reports, or National Practitioner Data Bank reports, at the time the report is filed.

IV. ATTACHMENTS

A. Monthly Credentialing Universe

V. REFERENCES

A. ~~2016-2017~~2018 NCQA Standards for the Accreditation
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~E. Health Network Service Agreement
~~E.~~F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~F.~~G. California Business and Professions Code, Section 805
~~G. CalOptima Policy AA.1000: Glossary of Terms~~
~~H. CalOptima Policy MA.1001: Glossary of Terms~~
~~I. CalOptima Policy CMC.1001 Glossary of Terms~~
~~J.~~H. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing
~~K.~~I. CalOptima Policy HH.2002Δ: Sanctions
~~L.~~J. CalOptima Policy HH.2005Δ: Corrective Action Plan
K. Medicare Managed Care Manual, Chapter 11, Section 110.~~2Title~~2

L. Medicare Managed Care Manual, Chapter 21, and Prescription Drug Benefit Plan, Chapter 9, Section 50.6.4
M. Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E)
N. Title 42, Code of Federal Regulations, Section 438.230(b)

VI. REGULATORY AGENCY APPROVALS

A. 06/29/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/ REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/1995	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	08/1998	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	02/2001	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Effective	08/01/2005	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	03/01/2007	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	07/01/2007	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Revised	09/01/2011	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	06/01/2014	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2015	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	09/01/2015	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/07/2017	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Retired	12/07/2017	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect
Revised	12/06/2018	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall ~~consists~~consist of senior management staff ~~that~~who may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance Officer; and Executive Director of Human Resources.
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 of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. First Tier, Downstream and Related Entities and/or CalOptima departments may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Delegated Entity	An entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement 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 health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and/or State governmental agencies, as applicable to the specific program.
Delegation	A legal assignment to another party of the responsibility for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.
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.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima program.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia(“PHCs”), Shared Risk Medical Groups (“SRGs”), and Health Maintenance Organizations(“HMOs”).
Member	A beneficiary who is enrolled in a CalOptima program.

Term	Definition
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Recredentialing	The process by which the qualifications of Practitioners are verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Practitioner	An individual who provides covered services pursuant to a state license, 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.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima of a Health Network or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.
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, Downstream or Related Entity's (FDR) or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Sub-Delegate	An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

Policy #:	GG.1605
Title:	**Delegation and Oversight of Credentialing and Recredentialing Activities**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader
Effective Date:	12/95
Last Review Date:	12/06/18
Last Revised Date:	12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy outlines the processes by which CalOptima shall ensure Credentialing and Recredentialing activities are performed by Delegated Entities in accordance with quality, state, and federal standards.

II. POLICY

A. CalOptima may delegate Credentialing and Recredentialing of a Practitioner to a Delegated Entity, in accordance with this policy.

B. CalOptima shall comply with California rules of Delegation of Quality Improvement Activities, in accordance with Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E), including continuous review of the quality of care provided.

C. CalOptima's quality assurance program shall be designed to ensure that:

1. Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to CalOptima providers, and/or others; and

2. CalOptima does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

D. CalOptima shall comply with Title 42, Code of Federal Regulations, Section 438.230(b), the Medicaid managed care regulation governing delegation and oversight, and the Medicare Managed Care Manual, Chapter, 11, Section 110.2.

E. CalOptima shall remain accountable for Credentialing and Recredentialing of its Practitioners, even if CalOptima delegates all or part of these activities.

1. Delegated activities may include, but are not limited to, processing credentialing applications, credentialing decision-making, development of decision-making criteria, credentialing policies and procedures, credentialing verification, credentialing file management, and monitoring of sanctions and exclusions.

F. CalOptima shall be responsible to perform a Readiness Assessment before implementing Delegation. This assessment will include verification that the Delegated Entity has devoted sufficient resources and appropriately qualified staff to perform the functions. The following shall be mutually agreed upon between CalOptima and the delegated party:

1. A written Delegation Acknowledgment and Acceptance Agreement Document (hereafter Delegation Agreement) describing all the delegated Credentialing activities; and

2. CalOptima shall retain the right to approve, suspend, and terminate individual Practitioners, providers, and sites in situations where CalOptima has delegated decision making, as addressed in the Delegation Agreement. CalOptima shall not sub-delegate Peer Review Body functions and the determination of a Practitioner's participation in the CalOptima program.

G. CalOptima shall monitor the performance of a Delegated Entity on an ongoing basis.

H. On an annual basis, CalOptima shall perform an audit of Credentialing written policies and procedures as well as a review of Credentialing files.

I. On a monthly basis, CalOptima shall evaluate required reports as agreed upon in the Delegation Agreement. CalOptima shall conduct a monthly Credentialing and Recredentialing file review, unless otherwise specified.

J. CalOptima shall identify and follow-up on opportunities for improvement, if applicable.

K. CalOptima shall require a Delegated Entity to respond to a Corrective Action Plan (CAP), based on any deficiency or area of non-compliance determined during the Readiness Assessment, monthly file review, or annual audit in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

III. PROCEDURE

A. Subject to CalOptima's approval of the delegated Credentialing and Recredentialing activities, the written Delegation Agreement shall include the following:

1. Mutual agreement demonstrated by signatures from both CalOptima and the Delegated Entity, and a description of:

a. Delegated activities;

b. CalOptima and the Delegated Entity responsibilities, which at a minimum include:

i. Acceptance of applications, reapplications, and attestations;

ii. Collection of all data elements from the National Committee for Quality Assurance (NCQA) or other appropriate sources, in accordance with CalOptima Policies;

iii. Collection and evaluation of ongoing monitoring information; and

iv. Decision-making in respect to oversight of Credentialing activities.

c. Reporting responsibilities and reporting frequency, which shall indicate a minimum of monthly reporting, unless specified otherwise. The reporting responsibilities shall be noted on the Timely and Appropriate Submissions Grid., and include

i. A list of Credentialed, Recredentialed, and Terminated Practitioners submitted monthly to CalOptima;

d. The process by which CalOptima evaluates the Delegated Entity's performance, which includes:

i. Readiness Assessment;

ii. Monthly file review;

iii. Annual audit; and

iv. Reporting.

e. Remedies available to CalOptima if the Delegated Entity does not fulfill its obligations, including revocation of the Delegation Agreement, and Sanctions as referenced in CalOptima Policy HH.2002Δ: Sanctions;

f. CalOptima's right to approve, suspend and terminate individual Practitioners, providers, and sites in situations where CalOptima has delegated decision-making; and

g. CalOptima's right to reject a Practitioner upon reason that the Practitioner has failed to meet the Credentialing or Recredentialing requirements, as outlined in the Delegation Agreement and CalOptima Policies.

B. Readiness Assessment

1. CalOptima shall conduct a Readiness Assessment of a Delegated Entity to determine the Delegated Entity's ability to implement delegated Credentialing and Recredentialing activities before entering into and implementing a Delegation Agreement.

2. The Readiness Assessment shall consist of a comprehensive desk review and on-site evaluation, utilizing the delegation oversight audit tool, which will evaluate a Delegated Entity's capacity to provide all delegated functions. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit. The evaluation shall include:

a. Written review of the Delegated Entity's understanding of applicable standards;

b. Delegated tasks;

c. Review of policies and procedures;

d. Staffing capabilities;

e. Performance records;

f. Review of Credentialing system; and

g. Credentialing and Recredentialing file review.

3. Upon completion of the Readiness Assessment, CalOptima's Director of Audit & Oversight shall report the Readiness Assessment results to the Audit & Oversight Committee (AOC) meeting.

4. The AOC shall determine if the Delegated Entity meets CalOptima's criteria for Delegation of Credentialing and Recredentialing activities based on the results of the Readiness Assessment.

a. If the AOC determines that a Delegated Entity does not meet CalOptima's criteria for Delegation of Credentialing and Recredentialing activities, CalOptima may reassess such Delegated Entity no earlier than three (3) months after the initial Readiness Assessment.

C. Delegated Entity Responsibilities

1. A Delegated Entity shall:

a. Develop and implement processes, in accordance with this policy, for the Credentialing and Recredentialing of Practitioners with whom it contracts or employs;

b. Develop policies and procedures that:

i. Are consistent with this policy, and specify:

a) Types of Practitioners covered;

b) Criteria for Credentialing and Recredentialing; and

c) Verification sources used.

ii. Address the following:

a) The process to delegate Credentialing or Recredentialing activities;

b) The process used to ensure that Credentialing and Recredentialing are conducted in a non-discriminatory manner;

c) The process for written notification to a Practitioner of any information obtained during the Delegated Entity's Credentialing process that varies substantially from the information provided by the Practitioner;

d) The process to ensure that Practitioners are notified of the Credentialing or Recredentialing decision within sixty (60) calendar days after the decision.

e) The medical director or other designated physician's direct responsibility and participation in the Credentialing program;

f) The process used to ensure the confidentiality of all information obtained in the Credentialing process, except as otherwise provided by law; and

g) The process for making Credentialing and Recredentialing decisions.

iii. Include the Practitioner's right to:

a) Review information submitted to support his or her Credentialing application;

b) Correct erroneous information;

c) Request information on the status of his or her Credentialing or Recredentialing application; and

d) Receive notification of these rights.

iv. Address ongoing monitoring of:

a) Medicare and Medicaid Sanctions;

b) State sanctions or limitations on licensure; and

c) Complaints and grievances.

c. Develop policies and procedures to verify the participation status of the Delegated Entity's agents to ensure that they shall:

i. Immediately disclose to CalOptima's Audit & Oversight Department any pending investigation involving, or any determination of, suspension, exclusion, or debarment by the Delegated Entity or its agents, occurring or discovered during the term of the Contract for Health Care Services; and

ii. Take immediate action to remove any Delegated Entity agent who does not meet participation status requirements from furnishing items or services related to the Health Network Service Agreement (whether medical or administrative) to Members.

d. Designate dedicated staff responsible for the timely Credentialing and Recredentialing of all Practitioners.

e. Credential and recredential Practitioners, in accordance with CalOptima Policies.

D. Sub-Delegation

1. A Delegated Entity shall not delegate any Credentialing or Recredentialing activity without prior written approval from CalOptima.

2. If a Delegated Entity delegates to a credentialing verification organization (CVO), CalOptima requires that the CVO be certified by NCQA. The Delegated Entity shall retain ultimate responsibility for any delegated activities.

3. Prior to delegating Credentialing activities, Delegated Entity shall evaluate the potential Sub-Delegate's capacity to perform such activities, according to CalOptima Credentialing and Recredentialing standards.

4. The delegated activities shall be described in a written Delegation Agreement with the Sub-Delegate. The agreement between the Delegated Entity and a Sub-Delegate shall include all of the following:

a. The responsibilities of each party;

b. The delegated activities;

c. The process by which a Delegated Entity shall evaluate the Sub-Delegate's performance;

d. The remedies, including revocation of Delegation, available to the Delegated Entity if the Sub-Delegate does not fulfill its obligations;

e. A process for submission of regular reports by the Sub-Delegate to the Delegated Entity;

f. The Delegated Entity shall provide ongoing monitoring of the Sub-Delegate’s activities under the agreement;

g. Both CalOptima and the Delegated Entity’s Peer Review Body shall retain the right to approve, terminate or suspend individual practitioners, providers or sites based upon quality issues;

h. Agreement as to the exchange of information between the Delegated Entity and the Sub-Delegate, including a definition of peer review or confidential information, and a process for sharing information with each other and with third parties;

i. A process for handling Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended; and

j. A monitoring and auditing schedule.

5. A Delegated Entity shall be responsible for providing oversight for all delegated Credentialing activities.

6. At least annually, Delegated Entity shall evaluate the Sub-Delegate's Credentialing process. The evaluation shall ensure that the delegated activities are conducted in accordance with CalOptima's Credentialing standards.

7. The Delegated Entity shall submit to CalOptima an annual report documenting the Delegated Entity's evaluation process of the delegated function.

8. CalOptima shall monitor the Delegated Entity's oversight process of the Sub-Delegate through CalOptima's annual oversight of the Delegated Entity's Credentialing and Recredentialing process.

E. Annual Audit

1. At least annually, CalOptima shall perform an audit of written policies and procedures as well as a review of Credentialing files to ensure compliance with all applicable NCQA, regulatory and contractual standards for each year that the Delegation is in effect. The annual audit shall be based on the responsibilities stated in the Delegation Agreement and performance of delegated activities, as well as the appropriate NCQA, regulatory and contractual standards. This audit may be performed on-site and/or via desktop review. Consideration will be given to utilizing a current Industry Collaboration Effort (ICE) Shared Credentialing Audit, if relevant CalOptima programs are included. Additional documentation may need to be provided to complete the audit.

2. The annual audit shall include the review of policies and procedures utilizing the delegation oversight annual audit tool. This audit will include, but not be limited to:

   a. A review of Delegated Entity's Peer Review Body meeting minutes, which shall be conducted for Credentialing and Recredentialing activities;

   b. A review to confirm the Delegated Entity's reporting procedure to CalOptima when there is action taken against a practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG), or the National Practitioner Data Bank (NPDB).)

3. An annual file review is also conducted utilizing the Credentialing and Recredentialing file review tool:

   a. CalOptima shall apply a targeted approach or select files with potential issue(s) of non-compliance when conducting the annual file review, and will provide the organization with the file selection.

      i. The number of files selected for each file type will vary depending on the audit area, its associated risk level, and/or the number of files available. Credentialing requirements applicable to both file types are scored for all files.

ii. At a minimum, CalOptima will select five (5) percent or fifty (50) files, whichever is less, to ensure that information is verified appropriately. The sample must include at least ten (10) Credentialing files and ten (10) Recredentialing files. If fewer than ten (10) Practitioners were credentialed or recredentialed since the last annual audit, CalOptima audits the universe of files rather than a sample.

b. If the requirement applies only to initial Credentialing files (e.g., work history) or to Recredentialing files (e.g., Recredentialing cycle length), the requirement is scored 'Not Applicable' for the file type that does not apply.

c. CalOptima shall review documentation of substantive evaluation and action plans, if needed.

d. If the Delegated Entity does not have any files for Credentialing or Recredentialing between audit cycles, CalOptima will not perform an annual audit, but instead shall require the Delegated Entity to meet all other delegation oversight requirements, and provide documentation that the Delegated Entity did not Credential or Recredential Practitioners between audit cycles.

4. Based on the results of the annual audit, CalOptima may take the following actions:

a. Require a Delegated Entity to respond to and submit a CAP addressing all areas of deficiency as determined by CalOptima in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan;

b. Audit the Delegated Entity's implementation and completion of an approved CAP, and any performance area(s) addressed in the CAP;

c. Impose Sanctions against a Delegated Entity, in accordance with CalOptima Policy HH.2002Δ: Sanctions;

d. Initiate the de-delegation process in accordance with Section III.F of this policy.

5. Annual audit findings and CAPs will be reported by the Audit & Oversight Department to the AOC with recommendations for follow-up activities and subsequently to the Compliance Committee for approval.

F. De-Delegation

1. The Audit & Oversight Credentialing Auditor shall review CAPs that do not meet the compliance threshold or are classified as 'deficient' and shall make appropriate recommendations to the AOC.

2. The AOC shall review a Delegated Entity's Delegation status based on the CAP timeline and level of achievement.

3. If a Delegated Entity fails to achieve compliance within the timeframes set forth in the CAP, the AOC may recommend de-delegation of Credentialing and Recredentialing.

4. If the AOC recommends de-delegation of Credentialing and Recredentialing activities from the Delegated Entity, and Compliance Committee approves the recommendation, CalOptima shall:

    a. Provide the Delegated Entity with thirty (30) calendar days written notice of CalOptima's intent to de-delegate;

    b. Inform Practitioners of the de-delegation and instructions for continued services;

    c. Adjust the Delegated Entity's payments, as appropriate, to the de-delegated status of Credentialing and Recredentialing activities;

    d. Prepare appropriate CalOptima departments to perform the de-delegated Credentialing and Recredentialing activities; and

    e. CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

5. A Delegated Entity shall cooperate with CalOptima to ensure a smooth transition and continuous care for Members during the de-delegation transition period.

6. CalOptima may re-evaluate a Delegated Entity's ability to perform delegated Credentialing and Recredentialing activities no sooner than twelve (12) months after de-delegation.

    a. CalOptima shall utilize the Readiness Assessment process, as described in Section III.B of this policy.

    b. CalOptima shall delegate Credentialing and Recredentialing activities to Delegated Entity based on the Readiness Assessment results.

    c. The Director of Audit & Oversight shall present the re-audit Readiness Assessment to the AOC.

    d. If the AOC recommends approval of delegation of Credentialing and Recredentialing activities to the Delegated Entity, and the Compliance Committee approves the recommendation, CalOptima shall re-delegate such activities, and adjust the Delegated Entity's payment accordingly.

    e. If the AOC recommends denial of re-delegation of Credentialing and Recredentialing activities to the Delegated Entity, it may also recommend additional Sanctions on the Delegated Entity, up to and including termination of the Contract for Health Care Services, to the Compliance Committee for final action and if the Compliance Committee concurs, CalOptima will not re-establish the Delegation of Credentialing and Recredentialing activities to the Delegated Entity.

7. CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

H. Exchange of Information

1. CalOptima may, at its discretion, share copies of a report received from a Delegated Entity regarding an adverse action, if CalOptima deems that such report may protect the medical care of a Member.

    a. Such reports may include, but are not limited to, action taken against a Practitioner that relates to professional behavior or clinical competence, suspensions, terminations, legal actions, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG) or the National Practitioner Data Bank (NPDB)).

    b. The provision of any such report to another Delegated Entity shall not relieve the Delegated Entity of an independent duty to comply with Credentialing procedures or to query or file a report with state or federal regulatory agencies.

2. CalOptima retains the right to review all components of a Delegated Entity's file.

I. Monitoring

1. CalOptima shall monitor a Delegated Entity's Credentialing and Recredentialing activities through reports, monthly file reviews, and continuous improvement activities.

    a. Monthly File Review

        i. On a monthly basis, CalOptima will review Credentialing and Recredentialing files for each delegate.

            a) CalOptima shall apply a targeted approach or select files with potential issue(s) of non-compliance when conducting the monthly file review.

                1. The number of files selected for each file type will vary depending on the monitoring activity, its associated risk level, and/or the number of files available.

                2. At a minimum, CalOptima will select five (5) percent or fifty (50) files, whichever is less, to ensure that information is verified appropriately. The sample must include at least ten (10) credentialing files and ten (10) Recredentialing files. If fewer than ten (10) Practitioners were credentialed or recredentialed since the last monthly file review, CalOptima reviews the universe of files rather than a sample.

        ii. The CalOptima auditor will notify the Delegated Entity via email of the file selection no later than the fourth (4^{th}) of every month.

        iii. The Delegated Entity shall submit the selected Credentialing and Recredentialing files to CalOptima on the tenth (10^{th}) of every month.

            a) Credentialing and Recredentialing files must be submitted via FTP server into the 'HN_Reporting' folder utilizing the instructed naming convention.

b. Monthly Credentialing Universe

i. Delegates that are NCQA-Certified or Accredited are exempt from the monthly file review, but are still required to submit monthly Credentialing universes.

ii. The monthly Credentialing universe is due to CalOptima on the second (2nd) day of every month.

a) Universes must be submitted via FTP server to the 'HN_Reporting' folder utilizing the instructed naming convention. Effective January 1, 2016, a single universe template will be utilized for reporting all contracted lines of business.

2. A Delegated Entity shall submit reports to CalOptima on a periodic basis, as specified by CalOptima on the Timely and Appropriate Submissions Grid, including, but not limited to, those reports based on the mutually agreed upon Delegation Agreement:

a. Reports shall include, but are not limited to:

i. Monthly Credentialing and Recredentialing reports;

ii. A list of all active Practitioners on an annual basis;

iii. Verification of Board Certification for Practitioners who claim Board Certification status; and

iv. Annual reports of any Sub-Delegate's performance, if CalOptima approved such Sub-Delegation.

b. A Delegated Entity shall also:

i. Notify CalOptima immediately of any investigation by a regulatory or licensing agency of a Practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., MBOC, OIG, NPDB); and

ii. Provide CalOptima copies of any California Business and Professions Code, Section 805 reports, or National Practitioner Data Bank reports, at the time the report is filed.

IV. ATTACHMENTS

A. Monthly Credentialing Universe

V. REFERENCES

A. 2018 NCQA Standards for the Accreditation
B. CalOptima Compliance Plan

C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. Health Network Service Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. California Business and Professions Code, Section 805
H. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing
I. CalOptima Policy HH.2002Δ: Sanctions
J. CalOptima Policy HH.2005Δ: Corrective Action Plan
K. Medicare Managed Care Manual, Chapter 11, Section 110.2
L. Medicare Managed Care Manual, Chapter 21, and Prescription Drug Benefit Plan, Chapter 9, Section 50.6.4
M. Title 28, California Code of Regulations, Section 1300.70(b)(1)(D) and (E)
N. Title 42, Code of Federal Regulations, Section 438.230(b)

VI. REGULATORY AGENCY APPROVALS

A. 06/29/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/ REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/1995	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	08/1998	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	02/2001	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Effective	08/01/2005	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	03/01/2007	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	07/01/2007	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Revised	09/01/2011	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2014	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2015	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	09/01/2015	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect
Revised	12/07/2017	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Retired	12/07/2017	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect
Revised	12/06/2018	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff who may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance Officer; and Executive Director of Human Resources.
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 of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. First Tier, Downstream and Related Entities and/or CalOptima departments may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
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Delegated Entity	An entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement 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 health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and/or State governmental agencies, as applicable to the specific program.
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Term	Definition
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Recredentialing	The process by which the qualifications of Practitioners are verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Practitioner	An individual who provides covered services pursuant to a state license, 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.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima of a Health Network or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.
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, Downstream or Related Entity's (FDR) or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Sub-Delegate	An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

1

Delegate Name: **ABC Medical Group**

Credentialing Universe

Medi-Cal (Y/N)	OneCare (Y/N)	OneCare Connect (Y/N)	License #	Last Name	First name	Middle Initial	Type (PCP, SCP, Mid-level)	Primary Contracted Specialty	Initial Decision Date MM/DD/YYYY	License to Practice (Y/N)

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Reporting Month/Year: **January 2016**

DEA/CDS Certificate (Y/N or N/A)	Board Certification (Y/N)	Board Cert Iss Date MM/DD/YYYY	Board Cert Exp Date MM/DD/YYYY (Lifetime = N/A)	Education & Training (Y/N)	Work History (Y/N)	Malpractice History (Y/N or N/A)	Reasons for Inability to Perform (Y/N or N/A)

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Lack of Drug Use (Y/N or N/A)	History of Loss of License (Y/N or N/A)	History of Felony Convictions (Y/N or N/A)	History of Loss or Limitation of Privileges (Y/N or N/A)	Current Malpractice Coverage (Y/N)	State sanctions, restrictions on licensure/practice (Y/N or N/A)	Medicare/Medicaid Sanctions (Y/N)

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Initial Site Visit MM/DD/YYYY	Evaluation of Medical Record Keeping Practices (Y/N)	Hospital Privileges (Y/N or N/A)	Current, signed attestation confirming the correctness and completeness of the application MM/DD/YYYY	Is Practitioner a designated HIV Specialist? (Y/N)	License Type

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Policy #:	GG.1619
Title:	**Delegation Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/96
Last Review Date:	~~12/07/17~~12/06/18
Last Revised Date:	~~12/07/17~~12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

~~*Board Approved Policy*~~

I. PURPOSE

This policy defines the process for oversight of Delegated Entities, including but not limited to Health Networks, Pharmacy Benefit Manager (PBM), and Managed Behavioral Health Organizations (MBHO), to ensure compliance with statutory, regulatory, contractual, and CalOptima policy requirements, and to ensure continuous improvement of Member care, management and administrative processes.

II. POLICY

A. CalOptima shall provide oversight of the functions and responsibilities, processes, and performance of a Delegated Entity and its Delegated Services.

B. CalOptima's oversight activities include review of compliance with regulatory requirements, contractual requirements and CalOptima policies and procedures. CalOptima's Audit ~~and~~& Oversight Department identifies whether a Delegated Entity's performance is adequate or inadequate and monitors a Delegated Entity's performance to ensure the improvement occurs where performance is inadequate.

C. CalOptima shall continually assess a Delegated Entity's ability to perform delegated functions through initial reviews, ongoing monitoring, performance reviews, analysis of data, and utilization of benchmarks, if available.

D. At a minimum, audits of Delegated Entities will be conducted annually by desktop review and by on-site review.

E. Successful completion of a ~~pre-delegation audit~~Readiness Assessment and resolution of any corrective actions will be required prior to delegating any function to a Delegated Entity, except as provided in this ~~policy~~Policy. This includes ~~delegation~~Delegation to a new entity, a Delegated Entity that changes its Management Services Organization (MSO), or a request to change a capitated hospital partner.

F. A Delegated Entity shall maintain and make available contracts, books, documents, records, and financial statements for inspection, evaluation, and auditing to:

1. CalOptima or its Designee;

2. Any authorized representative of the state or federal government, including the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), the U.S. Health and Human Services Office of Inspector General, the Comptroller General, the U.S. Department of Justice, and the Department of Managed Health Care~~;~~ (DMHC); and

3. Any quality improvement organization, accrediting organization (e.g.; National Committee for Quality Assurance~~),~~ (NCQA)), their Designees, and other representatives of regulatory or accrediting organizations.

G. CalOptima and its Delegated Entities shall maintain and make available contracts, books, documents, records and financial statements for a minimum of ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later.

H. A Delegated Entity agrees that CalOptima or its designated representatives, upon request, shall have the right to inspect, review, and make copies of such records, at the Delegated Entity's expense, to facilitate CalOptima's obligation to conduct oversight activities.

I. CalOptima retains the right to publish data obtained from audits and performance reviews, and may distribute such data to Members or the general public without further notice to, or consent from, a Delegated Entity.

J. CalOptima's Audit ~~and~~& Oversight Department shall maintain documentation of Delegated Entity oversight activities described herein.

K. Notwithstanding the processes described in this Policy, CalOptima's ~~delegation~~Delegation of activities and responsibilities to Delegated Entities is subject to CalOptima Board of ~~Directors~~Directors' approval of the underlying business relationship/contract.

III. PROCEDURE

A. CalOptima delegates activities to its ~~delegated entities~~Delegated Entities through the Contract for Healthcare Services and the Delegation Agreement, which incorporate DHCS and CMS contract requirements, regulations, and guidance, as well as any applicable regulations of the DMHC.

B. CalOptima shall provide oversight of all Delegated Entities, including proposed Delegated Entities; such oversight shall be conducted using, without limit, the following components:

1. ~~Pre-delegation assessment~~Readiness Assessment (desktop and on-site reviews);

2. Annual ~~assessment~~audit (desktop and on-site reviews);

3. Focused and ad hoc reviews, audits and monitoring;

4. Periodic reviews and audits; and

5. On-going monitoring.

C. Focus areas shall include, without limitation:

1. Quality Assurance and Quality Improvement (e.g., program, work plan, committee composition);

2. Credentialing, recredentialing and facility site review;

3. Staff and provider training and communication;

4. Case management, continuity of care and care transitions;

5. Financial solvency and minimum insurance requirements;

6. Utilization Management (e.g., program structure, workplan, committee composition, criteria, consistent application of criteria, adherence to established criteria of medical necessity, Member and provider notification, rates of admissions and readmissions, emergency room visits, under and over utilization, second opinions, expedited and standard review process, daily census for planned and unplanned admissions, screening Members admitted for potential transition of care issues, discharge planning, retrospective review, out-of-network process, urgent care services, timeliness, clinical decisions, denial notices, ~~and~~ emergency services, and structure);

7. Claims processing/adjudication and timely payment;

8. Encounters;

9. Information systems management;

10. Cultural and linguistic services;

11. Compliance Program;

12. Care Delivery Model (e.g.; Model of Care and Practice Guidelines);

13. Provider disputes and claim appeals;

14. Member rights;

15. Customer service;

16. Network management, including provider relations and provider network contracting;

17. Access and availability, including Americans with Disabilities Act (ADA);

18. Systems;

19. Ownership and control disclosures;

    a. CalOptima shall notify the DHCS contract manager within three (3) business days ~~of~~ upon discovery of a violation of compliance with the requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements;

20. Policies and procedures;

a. Delegated Entities shall facilitate and document an annual review of all their policies and procedures to ensure compliance with regulatory, statutory, and contractual requirements.

b. Delegated Entities shall review and obtain approval from all applicable executive management staff and from a regulatory agency, as appropriate.

c. Delegated Entities shall distribute policy and procedure updates to their employees, providers, and contractors, and ensure updated policies are posted in an accessible location for reference.

21. Reporting and monitoring; ~~and~~

22. Sub-delegation;~~.~~

23. Sub-Contractual, which is the area of focus that identifies the Delegated Entities of First Tier Entity and the policies and procedures used by the First Tier Entity to perform Delegation oversight;

24. Marketing;

25. Provider network contracting;

26. Provider relations;

27. Translation Services;

28. Insurance;

29. Medi-Cal addendum, which is the area of focus for Medi-Cal related changes relating to All Plan Letters that affect the First Tier Entities;

30. Member connections, which is an NCQA area of focus; and

31. Whole Child Model.

D. CalOptima's Audit ~~and~~& Oversight Department shall develop audit or other review tools for oversight of the focus areas as described in Section III.C of this ~~policy~~Policy, in consultation with subject matter experts including CalOptima operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. Such audit tools are reviewed and updated by the Audit ~~and~~& Oversight Department in collaboration with the respective subject matter experts annually, or more often, based upon~~,~~ regulatory, contractual and accreditation changes.

E. Pre-Delegation and Annual Review Communication/Notices

1. CalOptima may, at its discretion, provide a Delegated Entity with advance notice of a performance review.

2. Prior to the date of the review, CalOptima may notify a Delegated Entity, in writing, of the following:

a. Date and time of the performance review;

b. Proposed agenda;

c. Areas to be reviewed;

d. Review team members;

e. Audit items and files selected to be reviewed; and

f. Documents that must be available on-site or submitted to CalOptima prior to the review.

3. If CalOptima furnishes a document requirement list to the Delegated Entity prior to the scheduled date of the review, the ~~delegate entity would~~Delegate Entity shall perform the following:

a. The Delegated Entity shall compile and furnish all documents identified on the document requirement list to CalOptima on or before the date of the performance review.

i. The Delegated Entity shall ensure that the documents are organized to correspond and crosswalk to the categories identified on the document requirement list.

ii. If the Delegated Entity produces the documents at the time of the review, the Delegated Entity shall ensure that all responsive documents are available at the commencement of the review and organized to correspond to the categories identified on the required document list.

b. If the Delegated Entity is unable to furnish all required documents requested by CalOptima, CalOptima may impose Sanctions, including, but not limited to, payment for additional expenses incurred by CalOptima for independent audit vendors.

F. ~~Pre-Delegation~~Readiness Assessment Process

1. Prior to granting ~~delegation~~Delegation to a proposed Delegated Entity, CalOptima shall conduct a ~~pre-delegation readiness assessment~~ Readiness Assessment to determine the Delegated Entity's ability to implement proposed delegated activities.

2. Preliminary notification of prospective ~~delegation~~Delegation:

a. The CalOptima Contract Owner shall notify the Audit ~~and~~& Oversight Department of the prospective ~~delegation~~Delegation by completing the pre-~~delegation~~Delegation application form, which can be requested by submitting an email to auditoversight@caloptima.org. The notification must include the following and be submitted at least sixty (60) calendar days prior to potential "go live" of the delegated function:

i. Services and/or functions to be performed by the proposed Delegated Entity;

ii. Contact information (phone, facsimile, address and email address) for the proposed Delegated Entity;

iii. Mailing address of the proposed Delegated Entity, along with the addresses of all site locations;

iv. Lines of business proposed for Delegation;

v. Name and contact information of the CalOptima Contract Owner;

vi. Date of anticipated contract implementation; proposed service levels (performance standards) and reporting responsibilities of the proposed Delegated Entity; and

vii. Sub-delegate information, where applicable.

3. The CalOptima Audit ~~and~~& Oversight auditor shall conduct the ~~pre-delegation assessment~~Readiness Assessment and evaluation of the proposed Delegated Entity's ability to perform the Delegated Services.

4. Each proposed Delegated Entity and each individual proposed Delegated Service shall be subject to a ~~pre-delegation audit~~Readiness Assessment.

   a. A score of less than 100% on any individual ~~pre-delegationassessment~~Readiness Assessment will result in a Corrective Action Plan (CAP) request for each non-passing proposed Delegated Service in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

   b. Final Scores on ~~pre-delegationassessments~~Readiness Assessment for each Delegated Service shall not be combined to determine whether all proposed Delegated Services are to commence. Each delegated functional area audited will be evaluated separately.

5. The Audit ~~and~~& Oversight Department will schedule and conduct a ~~pre-delegation audit~~Readiness Assessment for all proposed Delegated Services sixty (60) calendar days in advance of the effective date of ~~delegation~~Delegation based on business needs.

   a. New entity: Desktop and on-site audit; and

   b. Expansion of service: Desktop audit.

6. It is the responsibility of Audit ~~and~~& Oversight Department to facilitate audit material submissions in partnership with the auditor. All ~~delegation~~Delegation materials shall be submitted to the Audit ~~and~~& Oversight Department within thirty (30) calendar days from the scheduled audit start date.

7. The auditor shall complete the applicable audit tool, document any deficiencies and request CAP(s) for any area receiving a score of less than 100%.

8. The auditor shall notify the Contract Owner of all findings and CAPs.

9. The auditor shall report to the Audit ~~and~~& Oversight Committee (AOC) the audit findings and CAPs, if any, and the ~~corrective action plan for~~ successful and timely resolution of the CAP. Contingencies, if applicable, will be noted by the AOC. The auditor may recommend the AOC

request approval by the Compliance Committee of the proposed ~~delegation~~Delegation, if the proposed Delegated Entity:

a. Meets 100% of the elements of the ~~pre-delegationassessment~~Readiness Assessment; or

b. Meets 100% of essential elements and 80% or more of the ~~nonessential~~non-essential elements and the proposed Delegated ~~entity~~Entity developed a CAP and/or is set for implementation for the remaining non-essential elements.

c. Notwithstanding the above, recommendation for approval may not be made if there are any findings of significant deficiencies.

10. The AOC shall make a recommendation to the Compliance Committee to approve or deny ~~delegation~~Delegation based on the reports from the ~~pre-delegation -assessment~~Readiness Assessment.

a. If the proposed Delegated Entity's request is denied:

i. The Audit ~~and~~& Oversight Department shall send a denial notice letter to the Delegated Entity.

ii. The proposed Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

b. If the proposed Delegated Entity's request is approved:

i. The Audit ~~and~~& Oversight Department shall notify the proposed Delegated Entity of the AOC approval.

ii. The Audit ~~and~~& Oversight Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

11. The AOC shall pend consideration of the proposed Delegated Entity if less than 100% of essential or 80% of non-essential elements are met. If there are contingencies, the Auditor shall ~~implement~~ issue the CAP(s) and the ~~Delegation~~Delegation team will notify the proposed Delegated Entity via email.

12. After AOC consideration, the Audit ~~and~~& Oversight Department shall send the proposed Delegated Entity the results of the assessment, findings and any request for CAP(s) within thirty (30) calendar days after completing a review.

13. All CAPs must be satisfactorily resolved within the timeframe approved by the AOC in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

14. Once the CAP(s) have been remediated to the satisfaction of the ~~auditor~~Auditor, the results will be presented to AOC by the Director of Audit ~~and~~& Oversight for review and recommendation.

14. The Director of Audit ~~and~~& Oversight shall report the AOC's recommendations on ~~pre-delegations audit~~ Readiness Assessment results to the Compliance Committee for approval.

15. Following AOC approval, and any other required approvals, of the Delegation Agreement and prior to the Delegated Entity's commencement of Delegated Service, the Audit ~~and~~& Oversight Department shall:

    a. Facilitate execution of the Delegation Agreement by the appropriate CalOptima Designee and the Delegated Entity; and

    b. Upon completion of the above, the Delegated Entity is considered approved to "go live."

G. Request to change capitated hospital partner

1. If and to the extent that CalOptima's Board policy allows for a change in delegated capitated partners, then both existing partners shall submit the request ~~–~~to the Health Network Relations Department.

2. The Health Network Relations Department shall forward all documents to the Audit ~~and~~& Oversight Department.

3. The Audit ~~and~~& Oversight Department shall review the request submitted by the Delegated Entity to determine if a ~~pre-delegation assessment~~ Readiness Assessment is necessary. The Audit ~~and~~& Oversight Department may conduct a desk review and/or an on-site assessment based on its review of the hospital partner's current financial statements, programs, plans or policies and procedures, and other documentation. CalOptima may forgo a desk review and/or an on-site assessment if it determines that the requesting hospital partner has demonstrated its capacity to implement CalOptima's program standards based on review of the request submitted for the assessment or based on CalOptima's current business relationship with the h~~H~~ospital p~~P~~artner.

    a. If it is determined that a ~~pre-delegation assessment~~ Readiness Assessment is not required, the Audit ~~and~~& Oversight Department shall present the request to change hospital partner to the AOC for a recommendation.

        i. Upon approval by the Compliance Committee of a recommendation by the AOC to deny a Delegated Entity's request to change hospital partner:

            ~~(a)~~a) The Audit ~~and~~& Oversight Department shall send a denial notice letter to the delegate.

            ~~(b)~~b) The Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

        ii. Upon approval by the Compliance Committee of a recommendation by the AOC to approve a Delegated Entity's request to change hospital partner, the Audit ~~and~~& Oversight Department shall notify the Delegated Entity of the AOC approval.

b. If it is determined that a ~~pre-delegation assessment~~Readiness Assessment is required, the Audit ~~and~~& Oversight Department shall coordinate the assessment with internal staff, the Delegated Entity and the potential hospital partner in accordance with this policy.

i. The Audit ~~and~~& Oversight Department shall present the results of the ~~pre-delegation assessment~~Readiness Assessment to the AOC for a recommendation to approve or deny the request.

a) ~~(a)~~ Upon approval by the Compliance Committee of a recommendation by the AOC to deny the Delegated Entity's request to change hospital partner, the Audit ~~and~~& Oversight Department shall send a denial notice letter to the Delegated Entity. The Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Policy MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

~~(b)~~b) Upon approval by the Compliance Committee of a recommendation by the AOC to approve of the Delegated Entity's request to change hospital partner, the Audit ~~and~~& Oversight Department shall notify the delegate of the AOC decision within thirty (30) calendar days after completing a review.

ii. The Health Network Relations Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

H. Request to Change Management Services Organization (MSO)

1. A Delegated Entity may request to change its MSO by submitting a request to the Health Network Relations Department.

2. The Health Network Relations Department shall forward all documents to the Audit ~~and~~& Oversight Department.

3. The Audit ~~and~~& Oversight Department shall review the request submitted by the Delegated Entity to determine if a ~~pre-delegation assessment~~Readiness Assessment is necessary. The Audit ~~and~~& Oversight Department may conduct a desk review and/or an on-site assessment based on its review of the MSO's current financial statements, programs, plans or policies and procedures and other documentation. CalOptima may forgo a desk review and/or an on-site assessment if it determines that the requesting MSO has demonstrated its capacity to implement CalOptima's program standards based on review of the request submitted for the assessment or based on CalOptima's current business relationship with the MSO.

a. If it is determined that a ~~pre-delegation assessment~~Readiness Assessment is not required, the Audit ~~and~~& Oversight Department shall present the request to change MSO to the AOC for a recommendation.

i. Upon approval by the Compliance Committee of a recommendation by the AOC to deny the Delegated Entity's request to change MSO:

(a) The Audit ~~and~~& Oversight Department shall send a denial notice letter to the Delegated Entity.

(b) The Delegated Entity ~~or~~ may appeal the decision by submitting an Appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

ii. Upon approval by the Compliance Committee of a recommendation by the ~~ACO~~AOC to approve the Delegated Entity's request to change MSO, the Audit ~~and~~& Oversight Department shall notify the Delegated Entity of the AOC approval.

b. If it is determined that a ~~pre-delegation assessment~~Readiness Assessment is required, the Audit ~~and~~& Oversight Department shall coordinate the assessment with internal staff, the Delegated Entity and the MSO in accordance with this P~~p~~olicy.

i. The Audit ~~and~~& Oversight Department shall present the results of the assessment to the AOC for a recommendation to approve or deny the request.

c. Upon approval by the Compliance Committee of a recommendation by the AOC to deny the Delegated Entity's request to change MSO, the Audit ~~and~~& Oversight Department shall send a denial notice letter to the Delegated Entity. The Delegated Entity may appeal the decision by submitting an ~~appeal~~Appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: Provider Complaint Process.

i. Upon approval by the Compliance Committee of the recommendation of the AOC to approve the Delegated Entity's or request to change MSO, ~~The~~the Audit ~~and~~& Oversight Department shall notify the delegate of the AOC decision within thirty (30) calendar days after completing a review.

ii. The Health Network Relations Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

I. Annual ~~Assessment~~Audit Process:

1. At least annually, the Audit ~~and~~& Oversight Department shall schedule an audit with the Delegated Entity. Oversight audits are required annually and shall be conducted as desktop and ~~onsite~~on-site Audits. The Audit ~~and~~& Oversight Department or the AOC may determine to conduct more frequent audits and/or targeted audits.

2. Using an audit tool developed as described in Section ~~IV~~III.D., the ~~audit~~Audit will evaluate, at a minimum, the Delegated Entity's performance of delegated activities and responsibilities, as evidenced by the Delegation Agreement, and compliance with applicable legal requirements, and CalOptima policies and procedures.

3. The A~~a~~udit will include validation based on documentation (e.g., policies & procedures, training, reports, systems) and file review(s). Scoring will be as follows:

Function	Elements Assessed	Elements Passed	Score Percentage
Policy Review (policies & procedures, training, reports, systems)	#	#	%
File Review	#	#	%
Total	#	#	%*

4. If the Delegated Entity receives a score of less than 100% on any A~~a~~udit element of the ~~delegation~~Delegation standards, the Delegated Entity shall be required to develop a CAP.

   a. The Auditor shall have ultimate responsibility for the CAP remediation and for monitoring and reporting the CAP to the AOC. The Auditor shall report the findings of the A~~a~~udit, the CAPs, if any, and the timeline for CAP remediation to the AOC.

5. Annual A~~a~~udit findings will be presented to the AOC, and the AOC shall determine the following based upon the Audit ~~and~~& Oversight Department's recommendations:

   a. Continued ~~delegation~~Delegation without interruption if 100% of the annual A~~a~~udit elements are met;

   b. Continued ~~delegation~~Delegation without interruption under a CAP in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan if scores are less than 100%; or

   c. Any ~~sanction~~Sanction that shall be imposed, such as suspension, revocation or termination, suspension of enrollment or other action in accordance with CalOptima Policy HH.2002Δ: Sanctions, if less than 80% of the annual A~~a~~udit elements are met.

6. CalOptima shall provide a Delegated Entity with a written report within thirty (30) calendar days after completing a review.

7. The elements of the CAP must be resolved in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

   a. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, ~~The~~the Director of Audit ~~and~~& Oversight shall report to the AOC following the CAP period. AOC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended or whether the Delegated Services should be revoked or terminated.

      i. The Audit ~~and~~& Oversight Department must demonstrate to the reasonable satisfaction of the AOC the reason for such an extension and provide a detailed, ~~internal,~~ step action plan to ensure that the items for correction are being addressed in a timely manner.

8. In accordance with CalOptima Policy HH.2002Δ: Sanctions, CalOptima may impose progressive disciplinary actions on Delegated Entity with consistent performance issues or findings regarding significant complaints. The Director of Audit ~~and~~& Oversight shall refer all incidents to the Compliance Committee for further action.

a. If de-~~delegation~~Delegation is recommended by the Audit ~~and~~& Oversight Department to AOC, the Compliance Committee would review the recommendation. If the Compliance Committee recommends de-~~delegation~~Delegation, the Contract Owner will be notified by the Audit ~~and~~& Oversight Department.

b. The Director of Audit ~~and~~& Oversight shall submit the AOC's recommendations on the A~~a~~udit results to the Compliance Committee.

9. If, at any time during the term of the Delegation Agreement, a non-compliance of ~~delegation~~Delegation issue arises, it should be referred immediately to the Audit ~~and~~& Oversight Department, who will alert the AOC. The AOC shall determine whether ad hoc A~~a~~udits, reviews, and or other remediation are necessary to resolve any identified issues. Issues escalated will be reviewed by the Audit ~~and~~& Oversight Department, AOC, and Compliance Committee, as applicable.

J. Ongoing Monitoring Process

1. Audit ~~and~~& Oversight Department, in conjunction with CalOptima Contract Owners, and functional business owners are responsible for reviewing and preparing monthly reports for each assigned Delegated Entity and each Delegated Service describing the on-going monitoring that is being performed related to the Delegated Entity and the Delegated Services.

2. CalOptima shall monitor a Delegated Entity through reports and continuous improvement activities submitted by the delegates on a periodic basis.

3. Delegated Entity Dashboard Reporting: On a monthly basis, data submitted by the Delegated Entities shall be used to monitor areas of timeliness and accuracy.

a. The AOC shall monitor the dashboards and may make recommendations for Corrective Action should metrics fall below the threshold.

b. If there is a consistent pattern of noncompliance by the Delegated Entity, the Audit ~~and~~& Oversight Department will conduct a focused review.

i. If the results of the ~~focus~~focused review are unfavorable, the Auditor will escalate to the AOC for further actions.

K. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified through any internal or external sources, including but not limited to, Member or provider complaints, ~~pre-delegation assessment~~Readiness Assessment reviews, regulatory A~~a~~udits, regular reports, oversight reviews, and ongoing monitoring, the Audit ~~and~~& Oversight Department may require a Delegated Entity to respond to and submit a CAP.

2. A Delegated Entity shall comply with CAP requirements as set forth in CalOptima Policy HH.2005Δ: Corrective Action Plan.

3. In accordance with CalOptima Policy HH.2002Δ: Sanctions, CalOptima may impose progressive disciplinary actions on Delegated Entity with consistent performance issues or findings regarding significant compliance issues~~aints.~~

L. Sub-~~Delegation~~Delegation Oversight Process

1. To ensure the Audit ~~and~~& Oversight Department has oversight of all sub-delegate arrangements and ~~is in~~sub-delegate(s) are ~~compliance~~ compliant with regulatory requirements, the Audit ~~and~~& Oversight Department shall monitor sub-~~delegation~~Delegation through the Readiness Assessment ~~pre-delegation assessment~~ and annual A~~a~~udit of the Delegated Entities. The sub-~~delegation~~Delegation attestation will be reviewed and signed during the Delegated Entity ~~pre-delegation assessment~~Readiness Assessment and annual A~~a~~udit and more frequently, if required by CalOptima.

2. Each Delegated ~~Entities~~Entity shall attest if they use sub-delegates to perform Delegated Services.

   a. Delegated Entities that sub-~~delegates~~delegate Delegated ~~Functions~~ Services shall provide a list of all sub-delegates and their functions.

   b. Delegated Entities that have sub-delegates must provide evidence of a Business Associates agreement holding the sub-delegate to all contractual obligations as outlined in the Business Associates agreement between the Delegated Entity and CalOptima.

M. Revocation of Delegation

1. Delegation may be revoked in instances where CalOptima or a regulatory agency determines that the Delegated Entity has not performed satisfactorily, including failing to implement a CAP or quality improvement plan. CalOptima may also terminate the Delegation Agreement at any time for cause related to findings of significant deficiencies.

2. The AOC may recommend to the Compliance Committee to approve complete or partial de-~~delegation~~Delegation of activities to a Delegated Entity.

3. Upon revocation or termination of Delegation~~;~~, performed Delegated Services shall be conducted by CalOptima or will be delegated to another party.

4. If the Compliance Committee approves de-~~delegation~~Delegation of activities from the Delegated Entity, CalOptima shall:

   a. Provide the Delegated Entity with a thirty (30) calendar day written notice of CalOptima's intent to de-delegate;

   b. Inform Members and providers of the de-~~delegation~~Delegation, and provide instructions for continued services;

   c. Adjust the Delegated Entity's payments as appropriate to the Delegated Entity activity; and

   d. Prepare appropriate CalOptima departments to provide the de-delegated activities.

5. A Delegated Entity shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the de-~~delegation~~Delegation transition period.

6. In the event CalOptima determines, in its sole discretion, that the circumstances warrant re-evaluation of a Delegated Entity's ability to perform delegated activities that were previously de-delegated, CalOptima shall conduct such re-evaluation no earlier than twelve (12) months after the effective date of the de-~~delegation~~Delegation.

   a. CalOptima shall utilize the ~~pre-delegationassessment~~Readiness Assessment process as described in Section IV.E of this policy.

   b. CalOptima shall delegate activities to the Delegated Entity based on the ~~pre-delegation assessment~~Readiness Assessment results.

   c. If the AOC approves ~~delegation~~Delegation of activities to the Delegated Entity, CalOptima shall re-delegate such activities, and adjust the Delegated Entity's payment accordingly.

   d. If the AOC denies re-~~delegation~~Delegation of activities to the Delegated Entity, it may recommend additional Sanctions on the Delegated Entity, up to and including termination of the Delegated Entity's Contract for Health Care Services.

7. CalOptima shall inform Providers of Providers' right to file Grievances in accordance with CalOptima Policy MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract for Health Care Services
~~B.~~C. 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 Contract for Health Care Services~~
~~E. CalOptima PACE Program Agreement~~
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima Policy MA.9006: Provider Complaint Process
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. ~~Delegation~~Delegation and Responsibility Agreement
L. Department of Health Care Services All-Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation
~~F.~~M. Health Network Service Agreement

~~G.A. Department of Health Care Services All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation~~
~~H.A. CalOptima Policy AA.1000: Glossary of Terms~~
~~I.A. CalOptima Policy HH.1101: CalOptima Provider Complaint~~
~~J.A. CalOptima Policy HH.2002A: Sanctions~~
~~K.A. CalOptima Policy HH.2005A: Corrective Action Plan~~
~~L.A. CalOptima Policy MA.9006: Provider Complaint Process~~
~~M.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
N. Title 42, Code of Federal Regulations (C.F.R.) §438.230
~~O.A. Delegation and Responsibility Agreement~~

VI. REGULATORY AGENCY APPROVALS

A. 07/03/17: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/1996	GG.1619	Health Network Delegation Oversight	Medi-Cal
Effective	04/01/1999	HH.2004	Health Network Performance Review	Medi-Cal
Revised	05/01/1999	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	12/01/1999	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	10/01/2002	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	10/01/2002	HH.2004	Health Network Performance Review	Medi-Cal
Revised	10/01/2003	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	11/01/2004	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	11/01/2004	HH.2004	Health Network Performance Review	Medi-Cal
Effective	08/01/2005	MA.7014	Physician Medical Group Delegation Oversight	OneCare
Effective	08/01/2005	MA.9103	Physician Group Performance Review	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	03/01/2007	MA.7014	Physician Medical Group Delegation Oversight	OneCare
Revised	04/01/2007	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	07/01/2007	HH.2004	Health Network Performance Review	Medi-Cal
Revised	01/01/2010	HH.2004	Health Network Performance Review	Medi-Cal
Effective	04/01/2010	MA.9111	Readiness Assessment	OneCare
Effective	08/01/2010	HH.2016	Readiness Assessment	Medi-Cal
Revised	09/01/2011	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	02/01/2013	HH.2004Δ	Performance Reviews	Medi-Cal OneCare
Revised	04/01/2014	HH.2004	Health Network Performance Review	Medi-Cal
Revised	10/01/2014	GG.1619	Delegation Oversight	Medi-Cal
Revised	09/01/2015	GG.1619	Delegation Oversight	Medi-Cal
Revised	09/01/2015	HH.2004	Health Network Performance Review	Medi-Cal
Revised	09/01/2015	HH.2016	Readiness Assessment	Medi-Cal
Revised	09/01/2015	MA.7014	Physician Medical Group Delegation Oversight	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9103	Health Network Performance Review	OneCare OneCare Connect
Revised	09/01/2015	MA.9111	Readiness Assessment	OneCare OneCare Connect
Revised	07/01/2017	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Retired	09/28/2017	HH.2004	Health Network Performance Review	Medi-Cal
Retired	09/28/2017	HH.2016	Readiness Assessment	Medi-Cal
Retired	09/28/2017	MA.7014	Physician Medical Group Delegation Oversight	OneCare OneCare Connect PACE
Retired	09/28/2017	MA.9103	Health Network Performance Review	OneCare OneCare Connect
Retired	09/28/2017	MA.9111	Readiness Assessment	OneCare OneCare Connect
Revised	12/07/2017	GG.1619	Delegation Oversight	Medi-Cal OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
				OneCare Connect
Revised	12/06/2018	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Contract Owner	The one individual within CalOptima with ultimate responsibility for the relationship between CalOptima and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on-going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CalOptima and the Delegated Entity is complete and accurate.
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), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Delegated Entity	An entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement 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 health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and or State governmental agencies, as applicable to the specific program.
Delegated Services	Services delegated to a Delegated Entity through a Delegation Agreement, which may include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing, sales and adjudicating organization determinations and appeals.
Delegation Agreement	The written agreement that specifies the terms and conditions of CalOptima's delegation to the Delegated Entity of specified activities and responsibilities as required by law.
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.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Management Services Organization (MSO)	For purposes of this policy, an entity that provides management and administrative support services on behalf of a Delegated Entity.

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.
Member	A beneficiary who is enrolled in a CalOptima program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
~~Pre-Delegation~~ Readiness Assessment	An assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CalOptima of the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.

Policy #:	GG.1619
Title:	**Delegation Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/96
Last Review Date:	12/06/18
Last Revised Date:	12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect

I. PURPOSE

This policy defines the process for oversight of Delegated Entities, including but not limited to Health Networks, Pharmacy Benefit Manager (PBM), and Managed Behavioral Health Organizations (MBHO), to ensure compliance with statutory, regulatory, contractual, and CalOptima policy requirements, and to ensure continuous improvement of Member care, management and administrative processes.

II. POLICY

A. CalOptima shall provide oversight of the functions and responsibilities, processes, and performance of a Delegated Entity and its Delegated Services.

B. CalOptima's oversight activities include review of compliance with regulatory requirements, contractual requirements and CalOptima policies and procedures. CalOptima's Audit & Oversight Department identifies whether a Delegated Entity's performance is adequate or inadequate and monitors a Delegated Entity's performance to ensure the improvement occurs where performance is inadequate.

C. CalOptima shall continually assess a Delegated Entity's ability to perform delegated functions through initial reviews, ongoing monitoring, performance reviews, analysis of data, and utilization of benchmarks, if available.

D. At a minimum, audits of Delegated Entities will be conducted annually by desktop review and by on-site review.

E. Successful completion of a Readiness Assessment and resolution of any corrective actions will be required prior to delegating any function to a Delegated Entity, except as provided in this Policy. This includes Delegation to a new entity, a Delegated Entity that changes its Management Services Organization (MSO), or a request to change a capitated hospital partner.

F. A Delegated Entity shall maintain and make available contracts, books, documents, records, and financial statements for inspection, evaluation, and auditing to:

1. CalOptima or its Designee;

2. Any authorized representative of the state or federal government, including the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), the U.S. Health and Human Services Office of Inspector General, the Comptroller General, the U.S. Department of Justice, and the Department of Managed Health Care (DMHC); and

3. Any quality improvement organization, accrediting organization (e.g.; National Committee for Quality Assurance (NCQA)), their Designees, and other representatives of regulatory or accrediting organizations.

G. CalOptima and its Delegated Entities shall maintain and make available contracts, books, documents, records and financial statements for a minimum of ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later.

H. A Delegated Entity agrees that CalOptima or its designated representatives, upon request, shall have the right to inspect, review, and make copies of such records, at the Delegated Entity's expense, to facilitate CalOptima's obligation to conduct oversight activities.

I. CalOptima retains the right to publish data obtained from audits and performance reviews, and may distribute such data to Members or the general public without further notice to, or consent from, a Delegated Entity.

J. CalOptima's Audit & Oversight Department shall maintain documentation of Delegated Entity oversight activities described herein.

K. Notwithstanding the processes described in this Policy, CalOptima's Delegation of activities and responsibilities to Delegated Entities is subject to CalOptima Board of Directors' approval of the underlying business relationship/contract.

III. PROCEDURE

A. CalOptima delegates activities to its Delegated Entities through the Contract for Healthcare Services and the Delegation Agreement, which incorporate DHCS and CMS contract requirements, regulations, and guidance, as well as any applicable regulations of the DMHC.

B. CalOptima shall provide oversight of all Delegated Entities, including proposed Delegated Entities; such oversight shall be conducted using, without limit, the following components:

1. Readiness Assessment (desktop and on-site reviews);

2. Annual audit (desktop and on-site reviews);

3. Focused and ad hoc reviews, audits and monitoring;

4. Periodic reviews and audits; and

5. On-going monitoring.

C. Focus areas shall include, without limitation:

1. Quality Assurance and Quality Improvement (e.g., program, work plan, committee composition);

2. Credentialing, recredentialing and facility site review;

3. Staff and provider training and communication;

4. Case management, continuity of care and care transitions;

5. Financial solvency and minimum insurance requirements;

6. Utilization Management (e.g., program structure, workplan, committee composition, criteria, consistent application of criteria, adherence to established criteria of medical necessity, Member and provider notification, rates of admissions and readmissions, emergency room visits, under and over utilization, second opinions, expedited and standard review process, daily census for planned and unplanned admissions, screening Members admitted for potential transition of care issues, discharge planning, retrospective review, out-of-network process, urgent care services, timeliness, clinical decisions, denial notices, emergency services, and structure);

7. Claims processing/adjudication and timely payment;

8. Encounters;

9. Information systems management;

10. Cultural and linguistic services;

11. Compliance Program;

12. Care Delivery Model (e.g.; Model of Care and Practice Guidelines);

13. Provider disputes and claim appeals;

14. Member rights;

15. Customer service;

16. Network management, including provider relations and provider network contracting;

17. Access and availability, including Americans with Disabilities Act (ADA);

18. Systems;

19. Ownership and control disclosures;

    a. CalOptima shall notify the DHCS contract manager within three (3) business days upon discovery of a violation of compliance with the requirements, and/or if a disclosure reveals any potential violation(s) of the ownership and control requirements;

20. Policies and procedures;

a. Delegated Entities shall facilitate and document an annual review of all their policies and procedures to ensure compliance with regulatory, statutory, and contractual requirements.

b. Delegated Entities shall review and obtain approval from all applicable executive management staff and from a regulatory agency, as appropriate.

c. Delegated Entities shall distribute policy and procedure updates to their employees, providers, and contractors, and ensure updated policies are posted in an accessible location for reference.

21. Reporting and monitoring;

22. Sub-delegation;

23. Sub-Contractual, which is the area of focus that identifies the Delegated Entities of First Tier Entity and the policies and procedures used by the First Tier Entity to perform Delegation oversight;

24. Marketing;

25. Provider network contracting;

26. Provider relations;

27. Translation Services;

28. Insurance;

29. Medi-Cal addendum, which is the area of focus for Medi-Cal related changes relating to All Plan Letters that affect the First Tier Entities;

30. Member connections, which is an NCQA area of focus; and

31. Whole Child Model.

D. CalOptima's Audit & Oversight Department shall develop audit or other review tools for oversight of the focus areas as described in Section III.C of this Policy, in consultation with subject matter experts including CalOptima operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. Such audit tools are reviewed and updated by the Audit & Oversight Department in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual and accreditation changes.

E. Pre-Delegation and Annual Review Communication/Notices

1. CalOptima may, at its discretion, provide a Delegated Entity with advance notice of a performance review.

2. Prior to the date of the review, CalOptima may notify a Delegated Entity, in writing, of the following:

a. Date and time of the performance review;

b. Proposed agenda;

c. Areas to be reviewed;

d. Review team members;

e. Audit items and files selected to be reviewed; and

f. Documents that must be available on-site or submitted to CalOptima prior to the review.

3. If CalOptima furnishes a document requirement list to the Delegated Entity prior to the scheduled date of the review, the Delegate Entity shall perform the following:

a. The Delegated Entity shall compile and furnish all documents identified on the document requirement list to CalOptima on or before the date of the performance review.

i. The Delegated Entity shall ensure that the documents are organized to correspond and crosswalk to the categories identified on the document requirement list.

ii. If the Delegated Entity produces the documents at the time of the review, the Delegated Entity shall ensure that all responsive documents are available at the commencement of the review and organized to correspond to the categories identified on the required document list.

b. If the Delegated Entity is unable to furnish all required documents requested by CalOptima, CalOptima may impose Sanctions, including, but not limited to, payment for additional expenses incurred by CalOptima for independent audit vendors.

F. Readiness Assessment Process

1. Prior to granting Delegation to a proposed Delegated Entity, CalOptima shall conduct a Readiness Assessment to determine the Delegated Entity's ability to implement proposed delegated activities.

2. Preliminary notification of prospective Delegation:

a. The CalOptima Contract Owner shall notify the Audit & Oversight Department of the prospective Delegation by completing the pre-Delegation application form, which can be requested by submitting an email to auditoversight@caloptima.org. The notification must include the following and be submitted at least sixty (60) calendar days prior to potential "go live" of the delegated function:

i. Services and/or functions to be performed by the proposed Delegated Entity;

ii. Contact information (phone, facsimile, address and email address) for the proposed Delegated Entity;

iii. Mailing address of the proposed Delegated Entity, along with the addresses of all site locations;

iv. Lines of business proposed for Delegation;

v. Name and contact information of the CalOptima Contract Owner;

vi. Date of anticipated contract implementation; proposed service levels (performance standards) and reporting responsibilities of the proposed Delegated Entity; and

vii. Sub-delegate information, where applicable.

3. The CalOptima Audit & Oversight auditor shall conduct the Readiness Assessment and evaluation of the proposed Delegated Entity's ability to perform the Delegated Services.

4. Each proposed Delegated Entity and each individual proposed Delegated Service shall be subject to a Readiness Assessment.

   a. A score of less than 100% on any individual Readiness Assessment will result in a Corrective Action Plan (CAP) request for each non-passing proposed Delegated Service in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

   b. Final Scores on Readiness Assessment for each Delegated Service shall not be combined to determine whether all proposed Delegated Services are to commence. Each delegated functional area audited will be evaluated separately.

5. The Audit & Oversight Department will schedule and conduct a Readiness Assessment for all proposed Delegated Services sixty (60) calendar days in advance of the effective date of Delegation based on business needs.

   a. New entity: Desktop and on-site audit; and

   b. Expansion of service: Desktop audit.

6. It is the responsibility of Audit & Oversight Department to facilitate audit material submissions in partnership with the auditor. All Delegation materials shall be submitted to the Audit & Oversight Department within thirty (30) calendar days from the scheduled audit start date.

7. The auditor shall complete the applicable audit tool, document any deficiencies and request CAP(s) for any area receiving a score of less than 100%.

8. The auditor shall notify the Contract Owner of all findings and CAPs.

9. The auditor shall report to the Audit & Oversight Committee (AOC) the audit findings and CAPs, if any, and the successful and timely resolution of the CAP. Contingencies, if applicable, will be noted by the AOC. The auditor may recommend the AOC request approval by the Compliance Committee of the proposed Delegation, if the proposed Delegated Entity:

   a. Meets 100% of the elements of the Readiness Assessment; or

b. Meets 100% of essential elements and 80% or more of the non-essential elements and the proposed Delegated Entity developed a CAP and/or is set for implementation for the remaining non-essential elements.

c. Notwithstanding the above, recommendation for approval may not be made if there are any findings of significant deficiencies.

10. The AOC shall make a recommendation to the Compliance Committee to approve or deny Delegation based on the reports from the Readiness Assessment.

    a. If the proposed Delegated Entity's request is denied:

        i. The Audit & Oversight Department shall send a denial notice letter to the Delegated Entity.

        ii. The proposed Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

    b. If the proposed Delegated Entity's request is approved:

        i. The Audit & Oversight Department shall notify the proposed Delegated Entity of the AOC approval.

        ii. The Audit & Oversight Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

11. The AOC shall pend consideration of the proposed Delegated Entity if less than 100% of essential or 80% of non-essential elements are met. If there are contingencies, the Auditor shall issue the CAP(s) and the Delegation team will notify the proposed Delegated Entity via email.

12. After AOC consideration, the Audit & Oversight Department shall send the proposed Delegated Entity the results of the assessment, findings and any request for CAP(s) within thirty (30) calendar days after completing a review.

13. All CAPs must be satisfactorily resolved within the timeframe approved by the AOC in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

14. Once the CAP(s) have been remediated to the satisfaction of the Auditor, the results will be presented to AOC by the Director of Audit & Oversight for review and recommendation.

14. The Director of Audit & Oversight shall report the AOC's recommendations on Readiness Assessment results to the Compliance Committee for approval.

15. Following AOC approval, and any other required approvals, of the Delegation Agreement and prior to the Delegated Entity's commencement of Delegated Service, the Audit & Oversight Department shall:

a. Facilitate execution of the Delegation Agreement by the appropriate CalOptima Designee and the Delegated Entity; and

b. Upon completion of the above, the Delegated Entity is considered approved to "go live."

G. Request to change capitated hospital partner

1. If and to the extent that CalOptima's Board policy allows for a change in delegated capitated partners, then both existing partners shall submit the request to the Health Network Relations Department.

2. The Health Network Relations Department shall forward all documents to the Audit & Oversight Department.

3. The Audit & Oversight Department shall review the request submitted by the Delegated Entity to determine if a Readiness Assessment is necessary. The Audit & Oversight Department may conduct a desk review and/or an on-site assessment based on its review of the hospital partner's current financial statements, programs, plans or policies and procedures, and other documentation. CalOptima may forgo a desk review and/or an on-site assessment if it determines that the requesting hospital partner has demonstrated its capacity to implement CalOptima's program standards based on review of the request submitted for the assessment or based on CalOptima's current business relationship with the hospital partner.

a. If it is determined that a Readiness Assessment is not required, the Audit & Oversight Department shall present the request to change hospital partner to the AOC for a recommendation.

i. Upon approval by the Compliance Committee of a recommendation by the AOC to deny a Delegated Entity's request to change hospital partner:

a) The Audit & Oversight Department shall send a denial notice letter to the delegate.

b) The Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

ii. Upon approval by the Compliance Committee of a recommendation by the AOC to approve a Delegated Entity's request to change hospital partner, the Audit & Oversight Department shall notify the Delegated Entity of the AOC approval.

b. If it is determined that a Readiness Assessment is required, the Audit & Oversight Department shall coordinate the assessment with internal staff, the Delegated Entity and the potential hospital partner in accordance with this policy.

i. The Audit & Oversight Department shall present the results of the Readiness Assessment to the AOC for a recommendation to approve or deny the request.

a) Upon approval by the Compliance Committee of a recommendation by the AOC to deny the Delegated Entity's request to change hospital partner, the Audit & Oversight Department shall send a denial notice letter to the Delegated Entity. The

Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Policy MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

b) Upon approval by the Compliance Committee of a recommendation by the AOC to approve of the Delegated Entity's request to change hospital partner, the Audit & Oversight Department shall notify the delegate of the AOC decision within thirty (30) calendar days after completing a review.

ii. The Health Network Relations Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

H. Request to Change Management Services Organization (MSO)

1. A Delegated Entity may request to change its MSO by submitting a request to the Health Network Relations Department.

2. The Health Network Relations Department shall forward all documents to the Audit & Oversight Department.

3. The Audit & Oversight Department shall review the request submitted by the Delegated Entity to determine if a Readiness Assessment is necessary. The Audit & Oversight Department may conduct a desk review and/or an on-site assessment based on its review of the MSO's current financial statements, programs, plans or policies and procedures and other documentation. CalOptima may forgo a desk review and/or an on-site assessment if it determines that the requesting MSO has demonstrated its capacity to implement CalOptima's program standards based on review of the request submitted for the assessment or based on CalOptima's current business relationship with the MSO.

a. If it is determined that a Readiness Assessment is not required, the Audit & Oversight Department shall present the request to change MSO to the AOC for a recommendation.

i. Upon approval by the Compliance Committee of a recommendation by the AOC to deny the Delegated Entity's request to change MSO:

(a) The Audit & Oversight Department shall send a denial notice letter to the Delegated Entity.

(b) The Delegated Entity may appeal the decision by submitting an Appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint.

ii. Upon approval by the Compliance Committee of a recommendation by the AOC to approve the Delegated Entity's request to change MSO, the Audit & Oversight Department shall notify the Delegated Entity of the AOC approval.

b. If it is determined that a Readiness Assessment is required, the Audit & Oversight Department shall coordinate the assessment with internal staff, the Delegated Entity and the MSO in accordance with this Policy.

i. The Audit & Oversight Department shall present the results of the assessment to the AOC for a recommendation to approve or deny the request.

c. Upon approval by the Compliance Committee of a recommendation by the AOC to deny the Delegated Entity's request to change MSO, the Audit & Oversight Department shall send a denial notice letter to the Delegated Entity. The Delegated Entity may appeal the decision by submitting an Appeal in accordance with CalOptima Policies MA.9006: Provider Complaint Process and HH.1101: Provider Complaint Process.

i. Upon approval by the Compliance Committee of the recommendation of the AOC to approve the Delegated Entity's or request to change MSO, the Audit & Oversight Department shall notify the delegate of the AOC decision within thirty (30) calendar days after completing a review.

ii. The Health Network Relations Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

I. Annual Audit Process:

1. At least annually, the Audit & Oversight Department shall schedule an audit with the Delegated Entity. Oversight audits are required annually and shall be conducted as desktop and on-site Audits. The Audit & Oversight Department or the AOC may determine to conduct more frequent audits and/or targeted audits.

2. Using an audit tool developed as described in Section III.D., the Audit will evaluate, at a minimum, the Delegated Entity's performance of delegated activities and responsibilities, as evidenced by the Delegation Agreement, and compliance with applicable legal requirements, and CalOptima policies and procedures.

3. The Audit will include validation based on documentation (e.g., policies & procedures, training, reports, systems) and file review(s). Scoring will be as follows:

Function	Elements Assessed	Elements Passed	Score Percentage
Policy Review (policies & procedures, training, reports, systems)	#	#	%
File Review	#	#	%
Total	#	#	%*

4. If the Delegated Entity receives a score of less than 100% on any Audit element of the Delegation standards, the Delegated Entity shall be required to develop a CAP.

    a. The Auditor shall have ultimate responsibility for the CAP remediation and for monitoring and reporting the CAP to the AOC. The Auditor shall report the findings of the Audit, the CAPs, if any, and the timeline for CAP remediation to the AOC.

5. Annual Audit findings will be presented to the AOC, and the AOC shall determine the following based upon the Audit & Oversight Department's recommendations:

    a. Continued Delegation without interruption if 100% of the annual Audit elements are met;

    b. Continued Delegation without interruption under a CAP in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan if scores are less than 100%; or

    c. Any Sanction that shall be imposed, such as suspension, revocation or termination, suspension of enrollment or other action in accordance with CalOptima Policy HH.2002Δ: Sanctions, if less than 80% of the annual Audit elements are met.

6. CalOptima shall provide a Delegated Entity with a written report within thirty (30) calendar days after completing a review.

7. The elements of the CAP must be resolved in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan.

    a. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Director of Audit & Oversight shall report to the AOC following the CAP period. AOC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended or whether the Delegated Services should be revoked or terminated.

        i. The Audit & Oversight Department must demonstrate to the reasonable satisfaction of the AOC the reason for such an extension and provide a detailed, step action plan to ensure that the items for correction are being addressed in a timely manner.

8. In accordance with CalOptima Policy HH.2002Δ: Sanctions, CalOptima may impose progressive disciplinary actions on Delegated Entity with consistent performance issues or findings regarding significant complaints. The Director of Audit & Oversight shall refer all incidents to the Compliance Committee for further action.

a. If de-Delegation is recommended by the Audit & Oversight Department to AOC, the Compliance Committee would review the recommendation. If the Compliance Committee recommends de-Delegation, the Contract Owner will be notified by the Audit & Oversight Department.

b. The Director of Audit & Oversight shall submit the AOC's recommendations on the Audit results to the Compliance Committee.

9. If, at any time during the term of the Delegation Agreement, a non-compliance of Delegation issue arises, it should be referred immediately to the Audit & Oversight Department, who will alert the AOC. The AOC shall determine whether ad hoc Audits, reviews, and or other remediation are necessary to resolve any identified issues. Issues escalated will be reviewed by the Audit & Oversight Department, AOC, and Compliance Committee, as applicable.

J. Ongoing Monitoring Process

1. Audit & Oversight Department, in conjunction with CalOptima Contract Owners, and functional business owners are responsible for reviewing and preparing monthly reports for each assigned Delegated Entity and each Delegated Service describing the on-going monitoring that is being performed related to the Delegated Entity and the Delegated Services.

2. CalOptima shall monitor a Delegated Entity through reports and continuous improvement activities submitted by the delegates on a periodic basis.

3. Delegated Entity Dashboard Reporting: On a monthly basis, data submitted by the Delegated Entities shall be used to monitor areas of timeliness and accuracy.

a. The AOC shall monitor the dashboards and may make recommendations for Corrective Action should metrics fall below the threshold.

b. If there is a consistent pattern of noncompliance by the Delegated Entity, the Audit & Oversight Department will conduct a focused review.

i. If the results of the focused review are unfavorable, the Auditor will escalate to the AOC for further actions.

K. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified through any internal or external sources, including but not limited to, Member or provider complaints, Readiness Assessment reviews, regulatory Audits, regular reports, oversight reviews, and ongoing monitoring, the Audit & Oversight Department may require a Delegated Entity to respond to and submit a CAP.

2. A Delegated Entity shall comply with CAP requirements as set forth in CalOptima Policy HH.2005Δ: Corrective Action Plan.

3. In accordance with CalOptima Policy HH.2002Δ: Sanctions, CalOptima may impose progressive disciplinary actions on Delegated Entity with consistent performance issues or findings regarding significant compliance issues

L. Sub-Delegation Oversight Process

1. To ensure the Audit & Oversight Department has oversight of all sub-delegate arrangements and sub-delegate(s) are compliant with regulatory requirements, the Audit & Oversight Department shall monitor sub-Delegation through the Readiness Assessment and annual Audit of the Delegated Entities. The sub-Delegation attestation will be reviewed and signed during the Delegated Entity Readiness Assessment and annual Audit and more frequently, if required by CalOptima.

2. Each Delegated Entity shall attest if they use sub-delegates to perform Delegated Services.

   a. Delegated Entities that sub-delegate Delegated Services shall provide a list of all sub-delegates and their functions.

   b. Delegated Entities that have sub-delegates must provide evidence of a Business Associates agreement holding the sub-delegate to all contractual obligations as outlined in the Business Associates agreement between the Delegated Entity and CalOptima.

M. Revocation of Delegation

1. Delegation may be revoked in instances where CalOptima or a regulatory agency determines that the Delegated Entity has not performed satisfactorily, including failing to implement a CAP or quality improvement plan. CalOptima may also terminate the Delegation Agreement at any time for cause related to findings of significant deficiencies.

2. The AOC may recommend to the Compliance Committee to approve complete or partial de-Delegation of activities to a Delegated Entity.

3. Upon revocation or termination of Delegation, performed Delegated Services shall be conducted by CalOptima or will be delegated to another party.

4. If the Compliance Committee approves de-Delegation of activities from the Delegated Entity, CalOptima shall:

   a. Provide the Delegated Entity with a thirty (30) calendar day written notice of CalOptima's intent to de-delegate;

   b. Inform Members and providers of the de-Delegation, and provide instructions for continued services;

   c. Adjust the Delegated Entity's payments as appropriate to the Delegated Entity activity; and

   d. Prepare appropriate CalOptima departments to provide the de-delegated activities.

5. A Delegated Entity shall cooperate with CalOptima to ensure smooth transition and continuous care for Members during the de-Delegation transition period.

6. In the event CalOptima determines, in its sole discretion, that the circumstances warrant re-evaluation of a Delegated Entity's ability to perform delegated activities that were previously

de-delegated, CalOptima shall conduct such re-evaluation no earlier than twelve (12) months after the effective date of the de-Delegation.

a. CalOptima shall utilize the Readiness Assessment process as described in Section IV.E of this policy.

b. CalOptima shall delegate activities to the Delegated Entity based on the Readiness Assessment results.

c. If the AOC approves Delegation of activities to the Delegated Entity, CalOptima shall re-delegate such activities, and adjust the Delegated Entity's payment accordingly.

d. If the AOC denies re-Delegation of activities to the Delegated Entity, it may recommend additional Sanctions on the Delegated Entity, up to and including termination of the Delegated Entity's Contract for Health Care Services.

7. CalOptima shall inform Providers of Providers' right to file Grievances in accordance with CalOptima Policy MA.9006: Provider Complaint Process and HH.1101: CalOptima Provider Complaint

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract for Health Care Services
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Policy AA.1000: Glossary of Terms
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima Policy MA.9006: Provider Complaint Process
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. Delegation and Responsibility Agreement
L. Department of Health Care Services All-Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation
M. Health Network Service Agreement
N. Title 42, Code of Federal Regulations (C.F.R.) §438.230

VI. REGULATORY AGENCY APPROVALS

A. 07/03/17: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/1996	GG.1619	Health Network Delegation Oversight	Medi-Cal
Effective	04/01/1999	HH.2004	Health Network Performance Review	Medi-Cal
Revised	05/01/1999	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	12/01/1999	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	10/01/2002	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	10/01/2002	HH.2004	Health Network Performance Review	Medi-Cal
Revised	10/01/2003	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	11/01/2004	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	11/01/2004	HH.2004	Health Network Performance Review	Medi-Cal
Effective	08/01/2005	MA.7014	Physician Medical Group Delegation Oversight	OneCare
Effective	08/01/2005	MA.9103	Physician Group Performance Review	OneCare
Revised	03/01/2007	MA.7014	Physician Medical Group Delegation Oversight	OneCare
Revised	04/01/2007	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	07/01/2007	HH.2004	Health Network Performance Review	Medi-Cal
Revised	01/01/2010	HH.2004	Health Network Performance Review	Medi-Cal
Effective	04/01/2010	MA.9111	Readiness Assessment	OneCare
Effective	08/01/2010	HH.2016	Readiness Assessment	Medi-Cal
Revised	09/01/2011	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	02/01/2013	HH.2004Δ	Performance Reviews	Medi-Cal OneCare
Revised	04/01/2014	HH.2004	Health Network Performance Review	Medi-Cal
Revised	10/01/2014	GG.1619	Delegation Oversight	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	GG.1619	Delegation Oversight	Medi-Cal
Revised	09/01/2015	HH.2004	Health Network Performance Review	Medi-Cal
Revised	09/01/2015	HH.2016	Readiness Assessment	Medi-Cal
Revised	09/01/2015	MA.7014	Physician Medical Group Delegation Oversight	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9103	Health Network Performance Review	OneCare OneCare Connect
Revised	09/01/2015	MA.9111	Readiness Assessment	OneCare OneCare Connect
Revised	07/01/2017	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Retired	09/28/2017	HH.2004	Health Network Performance Review	Medi-Cal
Retired	09/28/2017	HH.2016	Readiness Assessment	Medi-Cal
Retired	09/28/2017	MA.7014	Physician Medical Group Delegation Oversight	OneCare OneCare Connect PACE
Retired	09/28/2017	MA.9103	Health Network Performance Review	OneCare OneCare Connect
Retired	09/28/2017	MA.9111	Readiness Assessment	OneCare OneCare Connect
Revised	12/07/2017	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Revised	12/06/2018	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Contract Owner	The one individual within CalOptima with ultimate responsibility for the relationship between CalOptima and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on-going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CalOptima and the Delegated Entity is complete and accurate.
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), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Delegated Entity	An entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement 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 health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and or State governmental agencies, as applicable to the specific program.
Delegated Services	Services delegated to a Delegated Entity through a Delegation Agreement, which may include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing, sales and adjudicating organization determinations and appeals.
Delegation Agreement	The written agreement that specifies the terms and conditions of CalOptima's delegation to the Delegated Entity of specified activities and responsibilities as required by law.
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.
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Management Services Organization (MSO)	For purposes of this policy, an entity that provides management and administrative support services on behalf of a Delegated Entity.

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.
Member	A beneficiary who is enrolled in a CalOptima program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Readiness Assessment	An assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CalOptima of the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima.

1

Policy #:	HH.2014Δ
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	08/01/08
Last Review Date:	~~12/07/17~~1 2/06/18
Last Revised Date:	~~12/07/17~~1 2/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy establishes a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. POLICY

A. CalOptima shall establish a written Compliance Program, in accordance with applicable regulatory and contractual requirements.

B. CalOptima's First Tier, Downstream, and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this policy.

C. CalOptima shall revise and update the Compliance Program, including the Compliance Plan, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program, and approving the Compliance Plan and Code of Conduct.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, and related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan and Code of Conduct, to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan and/or Code of Conduct to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the Compliance Plan may be implemented without the need to obtain Board of Directors approval.

IV. ATTACHMENTS

~~Not Applicable~~
A. CalOptima Compliance Plan
B. FDR Compliance Attestation

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Office of Inspector General Guidelines for Operating an Effective Compliance Program
J. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504
K. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVALS

A. 07/12/13: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2005	MA.9101	Compliance Program	OneCare
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and ~~Policies~~policies and ~~Procedures~~procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
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 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	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 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.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima.
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.

Policy #:	HH.2014Δ
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	Michael Schrader
Effective Date:	08/01/08
Last Review Date:	12/06/18
Last Revised Date:	12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy establishes a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

II. POLICY

A. CalOptima shall establish a written Compliance Program, in accordance with applicable regulatory and contractual requirements.

B. CalOptima's First Tier, Downstream, and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this policy.

C. CalOptima shall revise and update the Compliance Program, including the Compliance Plan, and all applicable CalOptima policies, as changes occur in CalOptima's needs, regulatory requirements, and applicable laws.

D. The CalOptima Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program, and approving the Compliance Plan and Code of Conduct.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, and related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan and Code of Conduct, to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan and/or Code of Conduct to the Board of Directors for approval and adoption into the Compliance Program. Minor non-substantive revisions, specifically the correction of typographical or formatting errors, to the Compliance Plan may be implemented without the need to obtain Board of Directors approval.

IV. ATTACHMENTS

A. CalOptima Compliance Plan
B. FDR Compliance Attestation

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Medicare Managed Care Manual, 21
H. Medicare Prescription Drug Benefit Manual, Chapter 9
I. Office of Inspector General Guidelines for Operating an Effective Compliance Program
J. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504
K. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVALS

A. 07/12/13: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2005	MA.9101	Compliance Program	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014Δ	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	06/01/2013	MA.9101	Compliance Program	OneCare
Revised	06/01/2014	MA.9101	Compliance Program	OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9101	Compliance Program	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014Δ	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima's activities to which CalOptima's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Compliance Program	The program (including, without limitation, the Compliance Plan, Code of Conduct, and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, Employees and FDRs comply with applicable law and ethical standards.
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 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	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 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.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima.
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.

Orange County Health Authority

dba CalOptima

~~2018~~ 2019 Compliance Plan

(Revised December ~~2017~~2018)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, ~~PACE (~~Program of All-Inclusive Care for the Elderly (PACE), ~~MSSP (~~Multipurpose Senior Services Program (MSSP), and other ***CalOptima programs***.*~~.~~

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's ***First Tier***, ***Downstream***, and ***Related Entities*** (***FDRs***), such as ***health networks***, physician groups, ***participating providers*** ***and*** ~~,~~ ***suppliers***, pharmacy benefit manager (PBM), and consultants. The term ***FDR*** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the ***Centers for Medicare & Medicaid Services*** (***CMS***) and the ***Department of Health Care Services*** (***DHCS***). Such persons/entities, referred to as ***FDR*** herein, include those that directly contract with CalOptima and those that are ***Downstream*** or ***Related Entities*** (i.e., subcontracts) with CalOptima's ***First Tier Entities***.

CalOptima has developed a comprehensive ***Compliance Program*** applicable to all of CalOptima's p~~P~~rograms, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The ***Compliance Program*** incorporates all of the elements of an effective ***Compliance Program*** as recommended by the ***Office of the Inspector General*** (***OIG***) and required by ***CMS*** regulations. The ***Compliance Program*** is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima ***Board m~~M~~embers***, ***~~Employee~~employee***s, and ***FDRs*** conduct themselves in accordance with the requirements of CalOptima's ***Compliance Program***.

B. THE COMPLIANCE PLAN

This ***Compliance Plan*** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The ***Compliance Plan*** addresses the fundamental elements of an effective ***Compliance Program*** and identifies how CalOptima is implementing each of the fundamental elements of an effective ***Compliance Program*** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the ***Compliance Plan*** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** comply with contractual requirements, ethical standards, and applicable law.

This ***Compliance Plan*** is adopted by the ***Governing Body***. It was developed and is managed by the ***Executive Director of Compliance*** (referred to hereinafter as the "***Compliance Officer***") with the ***Compliance Committee***. Because the complex laws governing CalOptima and its programs are constantly evolving, the ***Compliance Plan*** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board mMembers, ~~Employee~~***employees***, and ***FDRs*** are expected to review and adhere to the requirements and standards set forth in the ***Compliance Plan***, the ***Code of Conduct***, and all related ***pPolicies and pProcedures***, as may be amended. Furthermore, ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a ***Board mMember***, ~~Employee~~***employee***, and/or ***FDR*** has/have any questions about the application, or implementation, of this ***Compliance Plan***, or questions related to the ***Code of Conduct*** or CalOptima ***pPolicies and pProcedures***, he or she should seek guidance from the ***Compliance Officer*** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***, CalOptima develops, maintains, and distributes its written standards in the form of this ***Compliance Plan***, a separate ***Code of Conduct***, and written ***pPolicies and pProcedures***.

a. Compliance Plan

As noted above, this ***Compliance Plan*** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***. This ***Compliance Plan*** also includes a comprehensive section articulating CalOptima's commitment to preventing ***Fraud***, ***Waste***, & ***Abuse*** (***FWA***), and setting forth guidelines and procedures designed to detect, prevent, and remediate ***FWA*** in the administration of ***CalOptima pPrograms***. The ***Compliance Plan*** is available on CalOptima's external website for ***Board mMembers*** and ***FDRs*** as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all ~~Employee~~***employees***.

b. Policies and Procedures

CalOptima also developed written ***pPolicies and pProcedures*** to address specific areas of CalOptima's operations, compliance activities, and ***FWA*** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are expected to be familiar with the ***pPolicies and pProcedures*** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The ***Compliance Officer***, or his/her ***dDesignee***, will ensure that ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The ***pPolicies and pProcedures*** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's ***pPolicies and pProcedures*** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's ***pPolicies and pProcedures***. ***Policies and pProcedures*** are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** receive notice when ***pPolicies and pProcedures*** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the ***Code of Conduct*** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the ***Code of Conduct*** is to articulate compliance expectations and broad principles that guide CalOptima ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** in conducting their business activities in a professional, ethical, and lawful manner. The ***Code of Conduct*** is a separate document from the ***Compliance Plan*** and can be found in Appendix A. The ***Code of Conduct*** is approved by CalOptima's Board of Directors and distributed to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** upon appointment, hire, or the commencement of the contract, and annually thereafter. New ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt and review of the ***Code of Conduct*** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the ***Compliance Program*** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the ***Compliance Officer***, the ***Compliance Committee***, the ***Audit & Oversight Committee***, and ***senior management***.

a. Governing Body

The ***CalOptima Board*** of Directors, as the ***Governing Body***, is responsible for approving, implementing, and monitoring a ***Compliance Program*** governing CalOptima's operations. The ***CalOptima Board*** delegates the ***Compliance Program*** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the ***Compliance Officer***. The ***Compliance Officer*** is an ***employee*** of CalOptima, who handles compliance oversight and activities full-time. The ***Compliance Officer***, in conjunction with the ***Compliance Committee***, are both accountable for the oversight and reporting roles and responsibilities as set forth in this ***Compliance Plan***. However, the ***CalOptima Board*** remains accountable for ensuring the effectiveness of the ***Compliance Program*** within CalOptima and monitoring the status of the ***Compliance Program*** to ensure its efficient and successful implementation.

To ensure the ***CalOptima Board*** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's ***Compliance Program***, the ***CalOptima Board***:

- Understands the content and operation of CalOptima's ***Compliance Program***;
- Approves the ***Compliance Program***, including this ***Compliance Plan*** and the ***Code of Conduct***;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the ***Compliance Program*** outcomes, including, but not limited to, results of internal and external ***audits***;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the ***Compliance Program***;

- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, ***Corrective Action Plans***, Warning Letters, and/or ***sanctions***;
- Receives regularly scheduled, periodic updates from CalOptima's ***Compliance Officer*** and ***Compliance Committee***, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the ***Compliance Program***.

The ***CalOptima Board*** reviews the measurable indicators of an effective ***Compliance Program*** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the ***CalOptima Board*** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The ***Executive Director of Compliance*** serves as the ***Compliance Officer*** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the ***Compliance Program***. The ***Compliance Officer*** reports directly to the CEO and the ***Compliance Committee*** on the activities and status of the ***Compliance Program***. The ***Compliance Officer*** has authority to report matters directly to the ***CalOptima Board*** at any time. Furthermore, the ***Compliance Officer*** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The ***Compliance Officer*** interacts with the ***CalOptima Board***, CEO, CalOptima's executive and departmental management, ***FDRs***, legal counsel, state and federal representatives, and others as required. In addition, the ***Compliance Officer*** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, ***FDR*** and internal oversight, ***p~~P~~olicies and p~~P~~rocedures***, and training on compliance activities.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Officer***, and/or his/her ***d~~D~~esignee***(s):

- Chair the ***Compliance Committee***, which shall meet no less than quarterly and assists the ***Compliance Officer*** in fulfilling his/her responsibilities;
- Ensure that the ***Compliance Program***, including this ***Compliance Plan*** and ***p~~P~~olicies and p~~P~~rocedures***, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected ***Board m~~M~~embers***, ~~Employee~~***employees***, and ***FDRs***, as appropriate;
- Oversee and monitor the implementation of the ***Compliance Program***, and provide regular reports no less than quarterly to the ***CalOptima Board*** and CEO summarizing all efforts,

including, but not limited to, the ***Compliance Committee***'s efforts to ensure adherence to the ***Compliance Program***, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and ***audit*** activities;

- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential ***FWA*** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal ***audits*** to ensure the ***Compliance Program*** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of ***Compliance Program*** activities for each of CalOptima's pPrograms, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or ***FWA*** issues, including facilitating any documentation or procedural requests by such agency~~/ies~~(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., ***DHCS*** and ***CMS***) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the ***CalOptima Board***, ~~Employee~~***employees***, and ***FDRs*** are knowledgeable about CalOptima's ***Compliance Program***, including the ***Code of Conduct***, ***pPolicies and pProcedures***, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate ***Corrective Action Plans***, ***sSanctions***, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and ***FDRs*** to ensure exclusion and preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), ~~and~~ Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List)~~)~~ has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The ***Compliance Committee***, chaired by the ***Compliance Officer***, is composed of CalOptima's ***senior management*** and operational staff, as designated by the CEO. The members of the ***Compliance Committee*** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the ***Compliance Committee*** is to implement and oversee the ***Compliance Program*** and to participate in carrying out the provisions of this ***Compliance Plan***. The ***Compliance Committee*** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the ***Compliance Program***.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Committee***:

- Maintain and update the ***Code of Conduct*** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the ***CalOptima Board***;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of ***Compliance Committee*** meetings reflecting reports made to the ***Compliance Committee*** and the ***Compliance Committee***'s decisions on the issues raised (subject to all applicable privileges);
- Review and ***Monitor*** the effectiveness of the ***Compliance Program***, including ***Monitoring*** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the ***Compliance Officer*** to ensure the adequacy of the ***Compliance Program***;
- Review, approve, and/or update ***pPolicies and pProcedures*** to ensure the successful implementation and effectiveness of the ***Compliance Program*** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and ***pPolicies and pProcedures*** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the ***Compliance Officer*** accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of ***mMmMonitoring*** and aAuditing of areas in which CalOptima is at risk of program non-compliance and/or potential ***FWA***, and ensure ***CAPs*** and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its ***FDRs*** conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the ***CalOptima Board of Directors***.

d. Audit & Oversight Committee (AOC)

The ***Audit & Oversight Committee*** (***AOC***) is a subcommittee of the ***Compliance Committee*** and is ~~chaired~~ co-led by the Director(s) of Audit & Oversight. The ***AOC*** is responsible for overseeing the delegated and internal activities of CalOptima. The ***Compliance Committee*** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima P~~p~~olicy HH.4001Δ: ~~(~~Audit & Oversight Committee~~)~~~~the *AOC* charter~~. In addition to the monthly scheduled meetings, the ***AOC*** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the ***AOC*** ~~presented~~ are approved by the majority of a quorum of the ***AOC***. A quorum is defined as one (1) over fifty percent (50%). The ***AOC*** may approve and/or implement ***Corrective Action Plans*** (***CAPs***); however, recommendations for ***FDR*** sanctioning and/or de-***delegation*** are submitted to the ***Compliance Committee*** for final approval. The ***AOC*** also contributes to external reviews and

accreditation ***audits***, such as the ***National Committee for Quality Assurance*** (***NCQA***).

Responsibilities of the ~~***Audit & Oversight Committee***~~***AOC*** with regard to ***FDRs*** include:

- Annual review, revision, and approval of the ***audit*** tools;
- Review findings of the ~~pre ***delegation audit*** and~~ readiness assessment to evaluate a potential ***FDR***'s ability to perform the delegated function(s);
- Review and approve potential ***FDR*** entities for ***delegation*** of functions;
- Ensure written agreements with each delegated ***FDR*** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and monitoring of ***FDR*** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite ***audit***;
- Ensure all ***Downstream*** and ***Related Entities*** are monitored in accordance with CalOptima oversight procedures;
- Ensure that~~Conduct~~ formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues;
- Propose s~~S~~***anctions***, subject to the ***Compliance Committee***'s approval, if an ***FDR***'s performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of ***delegation***, to the ***Compliance Committee*** for unresolved issues of compliance.

Responsibilities of the ~~***Audit & Oversight Committee***~~***AOC*** with regard to internal business functions include:

- Annual review, revision, and approval of the ~~Audit & Oversight Department Program Description~~audit work plan and ***audit*** tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual ***audit***;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the ***Compliance Officer*** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective ***Compliance***

Program;

- Receive periodic reports from the ***Compliance Officer*** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including ***audit*** findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the ***Compliance Program***. CalOptima requires that all ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's ***Code of Conduct***, compliance obligations, and relevant laws, and ***FWA***, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the ***Compliance Program***, and which courses are updated regularly to ensure that ***employees*** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The ***Compliance Officer***, or his/her ***designee*** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/***FDR***'s completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The ***Compliance Officer*** and the CalOptima management staff are responsible for ensuring that ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's ***Code of Conduct*** to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt, review, and understanding of the ***Code of Conduct*** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the ***Code of Conduct*** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each ~~person's~~ individual's personnel file~~s~~, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the ***Compliance Program***; ***FWA*** training; Health Insurance Portability and Accountability Act of 1996 (***HIPAA***) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the ***Compliance Program*** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or ***FWA*** issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's ***HIPAA*** privacy and security training course covers the administrative,

technical, and physical safeguards necessary to secure ***members***' protected health information (PHI) and personally identifiable information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the ***Compliance Program*** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each ~~Employee~~***employee***. ***Board m~~M~~embers*** and ***FDRs*** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some ***FDRs*** may be exempt or deemed to have met the ***FWA*** training and education requirement if the ***FDR*** has met the ***CMS*** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the ***Compliance Program***. These training opportunities are available to ***managers*** and ~~Employee~~***employees*** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing ***managers*** the tools and resources to train and share the information with ~~Employee~~***employees*** in their respective departments. If additional training related to ***FWA*** is required, the ***Compliance Officer***, or his/her ***designee,*** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's ***p~~P~~olicies and p~~P~~rocedures*** governing the ***Compliance Program*** and pertinent to their respective roles and responsibilities. ***Employees*** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board m~~M~~embers receive a copy of the ***Compliance Plan***, ***Code of Conduct***, and ***p~~P~~olicies and p~~P~~rocedures*** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the ***CalOptima Board***. ***Board m~~M~~embers*** may receive additional compliance training related to the ***CalOptima Board***'s role in overseeing and ensuring organizational compliance with CalOptima's ***Compliance Program***.

The ***Code of Conduct*** and ***p~~P~~olicies and p~~P~~rocedures*** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to ***FDRs*** upon commencement of the ***FDR*** contract. ***FDRs*** are required to disseminate copies of the ***Code of Conduct*** and ***p~~P~~olicies and p~~P~~rocedures*** to their ***employees***, agents, and/or ***Downstream Entities***. CalOptima may also develop compliance training and education presentations and/or roundtables for specified ***FDRs***.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the ***Compliance Program*** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to ***pPolicies and pProcedures***, contact information for the ***Compliance Officer***, relevant federal and state ***fraud*** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the ***Compliance Officer*** to CalOptima ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***members***, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the ***CalOptima Board***, ***FDRs***, ~~Employee~~***employees***, individual CalOptima departments, and ***members***.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***, which contains CalOptima's updated ***pPolicies and pProcedures***.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***mMembers***.
- Electronic Mail – The CEO, ***Compliance Officer***, or their respective ***dDesignee***, periodically sends out email communications and/or alerts to ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and/or ***mMembers***, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to ~~Employee~~***employees***.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima ~~Employee~~***employees*** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the ***Compliance Program***, ***Code of Conduct***, and/or ***pPolicies and pProcedures***.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and ***FWA*** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima ~~Employee~~***employees***.
- Written Reports – The ***Compliance Officer***, in coordination with the CEO and ***Compliance Committee***, prepares written monthly reports concerning the status of the ***Compliance Program*** to be presented to the ***CalOptima Board***.
- Direct Contact with the ***Compliance Officer*** - ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** can obtain additional compliance information directly from the ***Compliance Officer***. Any questions, which cannot be answered by the ***Compliance Officer***, shall be referred to the ***Compliance Committee***.

b. Reporting Mechanisms

CalOptima ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** have an affirmative duty and are directed in CalOptima's ***Code of Conduct*** and ***pPolicies and pProcedures*** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by ***Board mMembers***, ~~Employee~~***employees***, and/or ***FDRs*** to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an ***FDR*** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or ***FWA*** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and ***FWA*** issues are also provided to ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***mMembers*** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or ***FWA***.

Upon receipt of a report through one (1) of the listed mechanisms, the ***Compliance Officer***, ~~or~~ his/her ***designee,*** shall follow appropriate ***pPolicies and pProcedures*** to promptly review, investigate, and resolve such matters. The ***Compliance Officer***, or his/her ***designee,*** shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to a Supervisor or Manager*

CalOptima ***employees*** are encouraged to contact their immediate ***sSupervisor***, or ***mManager***, when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. The ***sSupervisor***, or ***mManager***, will promptly escalate the report to the ***Compliance Officer*** for further investigation and reporting to the CalOptima ***Compliance Committee***. If an ~~Employee~~***employee*** is concerned that his/her ***sSupervisor*** or ***mManager*** did not adequately address his/her report or complaint, the ~~Employee~~***employee*** may go directly to the ***Compliance Officer***, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. ***Members*** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or ***FWA*** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all ***Board mMembers***, ~~Employee~~***employees***, ***FDRs***, and ***mMembers***. ***Members*** also have access to the ***Compliance Officer*** through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline directly.

3. *Report Directly to the Compliance Officer*

The ***Compliance Officer*** is available to receive reports of suspected or actual compliance violations, or ***FWA*** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from ***Board mMembers***, ~~Employee~~***employees***, ***FDRs*** and ***members***. The ***Compliance Officer*** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. ***FDRs*** are generally contractually obligated to report suspected ***fFraud*** and ***aAbuse*** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or ***FWA***, issues in good faith. This non-retaliation policy extends to reports received from ***FDRs*** and ***mMembers***. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the ***Compliance Officer*** will review and enforce disciplinary and/or other ***Corrective Action Plans*** for violations, as appropriate, with the approval of the ***Compliance Committee***.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board mMembers, ~~Employee~~***employees***, and ***FDRs*** are provided copies of CalOptima's ***Code of Conduct*** and the ***Compliance Plan*** and have access on CalOptima's internal and external website to applicable ***pPolicies and pProcedures***, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards ~~'s Progressive Discipline Policy~~ and Office of Compliance Policies addressing ***Corrective Action Plans*** and ***sSanctions***. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board mMembers, ~~Employee~~***employees***, and ***FDRs*** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the ***Compliance Program*** documents and related ***pPolicies and pProcedures***, including CalOptima~~'s Progressive Discipline Policy~~ Policy GA.8022: Performance and Behavior Standards, as applicable. ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's ***Compliance Program*** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in ***Federal and/or State hHealth cCare pPrograms***;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, ***pPolicies and pProcedures*** and/or contracts; or
- Failure to report violations or suspected violations of the ***Compliance Program***, or applicable laws, or to report suspected or actual ***FWA*** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates ***HIPAA*** and other privacy laws and/or CalOptima's ***HIPAA*** privacy and security policies, including actions that harm the privacy of ***members***, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the ***Compliance Program*** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, ***sSanctions***, and/or termination, depending on the nature and severity of the conduct, or behavior. ***Board mMembers*** may be subject to removal, ~~Employee~~***employees*** are subject to discipline, up to and including termination, and ***FDRs*** may be sanctioned, or contracts may be terminated, where

permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative ***sSanctions*** and/or penalties. Further violations could lead to suspension, preclusion, or exclusion, from participation in ***Federal and/or State hHealth cCare pPrograms***.

CalOptima ~~Employee~~***employees*** shall be evaluated annually based on their compliance with CalOptima's ***Compliance Program***. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, Audit & Oversight and ***Compliance Committee*** discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The ***Compliance Officer***, or his/her ***designee***, will collaborate with the ***Compliance Committee*** to identify areas of focus for monitoring and auditing potential non-compliant activity and ***FWA*** issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of ***FDRs***. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external ***audit*** and ***monitoring*** reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by ***CMS*** and the OIG Work Plan shall be used as resources to evaluate operational risks.

The ***Compliance Officer***, or his/her ***designee***, will work with the Chief Operating Officer, or his/her ***dDesignee***, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject to more frequent monitoring and auditing, as well as additional reporting requirements. The risk assessment process will be managed by the ***Compliance Officer***, or his/her ***dDesignee***, and presented to the ~~***Audit & Oversight Committee (AOC)***~~, and subsequently to the ***Compliance Committee***, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused ***audits*** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine ~~monitoring~~ auditing and ~~***auditing***~~ ***monitoring activities*** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima ***pPolicies and pProcedures*** to protect against non-compliance and potential ***FWA*** in ***CalOptima pPrograms***. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. ***Monitoring activities*** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An ***audit*** is 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., ***pPolicies and pProcedures***, laws, and regulations) used as base measures. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances,

regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The ***Compliance Officer***, or his/her ***designee,*** in collaboration with the ***AOC*** and ***Compliance Committee***, develops the monitoring and auditing work plans to address the risks associated with each of ***CalOptima's ~~P~~programs***.

The ***Compliance Officer***, or his/her ***designee,*** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate auditing and ***monitoring activities***. ***Audits*** for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer, or his/her ***designee,*** will coordinate the ***audits*** with internal ***audit*** staff, and, in some cases, with the assistance from an outside vendor. ***Audit*** methodologies shall be consistent with regulatory and NCQA requirements and standards. All ***audits*** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the ***audit*** review is completed, the ***audit*** team will communicate the results to the ***Compliance Officer*** and propose follow up corrective action(s), if necessary. The ***Compliance Officer***, or his/her ***designee,*** will provide reports to the CEO and the ***Compliance Committee*** concerning the results of the ***audits***. The ***AOC*** reports to the ***Compliance Officer*** and the ***Compliance Committee*** on ***audits*** that involve ***FDRs*** as discussed below. If ~~Fraud, Waste, or Abuse (~~***FWA***~~)~~ issues are identified during an ***audit***, the matter will be further investigated and resolved in a timely manner. In addition, an ***audit*** of the ***Compliance Program*** and its effectiveness should occur at least annually, and the results shall be reported to the ***CalOptima Board***.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to ***CMS***, ***DHCS***, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of ***FDRs*** who perform delegated activities. The processes that CalOptima implements to oversee, monitor, and ***audit FDRs*** are incorporated into CalOptima's written ***p~~P~~olicies and p~~P~~rocedures***, including processes involving pre-contractual evaluations and ***audits*** of ***First Tier Entities***. CalOptima may implement ***Corrective Action Plans***, ***s~~S~~anctions***, and/or revoke its ***delegation*** of duties (in a manner permitted under the contract) if CalOptima determines that an ***FDR*** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The ***Compliance Officer***, or his/her ***d~~D~~esignee***, determines the process for monitoring delegated ***FDRs*** and develops the annual monitoring and ***audit*** calendar in order to ~~validate~~validate compliance with contractual standards and regulatory requirements. The ***AOC*** is responsible for overseeing all of the delegated activities and will review the ~~***pre-delegation audit***~~readiness assessment, ensure the annual review of ***FDRs*** for delegated functions are completed, conduct formal on-going evaluation of ***FDR*** performance and compliance, ensure ***Downstream*** and ***Related Entit~~i~~es*** are monitored, and impose ***Corrective Action Plans*** and/or ***s~~S~~anctions*** if the ***FDR***'s performance fails to meet statutory and contractual standards and requirements. The ***AOC*** may recommend termination of ***delegation*** to

the ***Compliance Committee*** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or ***delegation*** agreement with a potential ***FDR***, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's ***pPolicies and pProcedures***, is completed to determine the ability of the potential ***FDR*** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, ***CMS***, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not precluded on the Preclusion List, excluded in the OIG- List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the ***DHCS*** Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the ~~Audit & Oversight Committee~~***AOC*** and subsequently the ***Compliance Committee*** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the ***delegation*** agreement specifies the activities CalOptima delegates to the ***FDRs***, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and ***audits***, and remedies, including disciplinary actions, available to CalOptima. Prior to any ***sub-delegation*** to any ***Downstream*** or ***Related Entity***, a ***First Tier Entity*** must obtain approval from CalOptima. CalOptima determines who will directly monitor the ***Downstream*** or ***Related Entity***'s compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the ***FDR*** and their contractually delegated area(s). Furthermore, ***FDRs*** will be required to complete, sign, and return attestation forms confirming the ***FDR***'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and ***FWA*** as well as exclusion and preclusion screening and ***FWA*** reporting obligations.

3. *Annual Risk Assessment*

The ***Compliance Officer***, or his/her ***dDesignee***, will ensure that~~conduct~~ an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the ***FDR***'s vulnerabilities and high-risk areas. High risk ***FDRs*** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or

complaints and appeals from the previous year will be factors that are included in the risk assessment. Any ***FDR*** deemed high risk, or vulnerable, is presented to the ***AOC*** for suggested follow-up ***audit***. ***FDRs*** determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from ***FDRs***, will be managed by the ***Compliance Officer***, or his/her ***dDesignee***, and presented to the ***AOC*** and subsequently to the ***Compliance Committee*** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the ***FDR***'s ability to provide delegated services in accordance with contractual standards and applicable state, ***CMS***, and accreditation requirements, as further detailed in CalOptima's ***pPolicies and pProcedures***. CalOptima may conduct ***audits*** of ***FDRs*** at any time. Such ***audits*** may include an evaluation of the ***FDR***'s training and education program and materials covering general compliance and ***FWA***, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk ***FDRs***, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual ***audit*** calendar; however, CalOptima does not limit its auditing schedule to only high-risk ***FDRs***.

If CalOptima has reason to believe the ***FDR***'s ability to perform a delegated function is compromised, an additional focused ***audit*** may be performed. The ***Compliance Officer***, or his/her ***designee***, may also recommend focused ***audits*** upon evaluation of non-compliant trends or reported incidents. The results of these ***audits*** will be reported to the ***AOC*** and then to the ***Compliance Committee***.

A focused ***audit*** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or ~~the~~ CalOptima's service level performance indicators;
- Failure to comply with a ***Corrective Action Plan***;
- Reported or alleged ***fFraud***, ***wWaste***, and/or ***aAbuse***;
- Significant policy variations that deviate from the CalOptima or state, ***CMS***, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to ***members*** (either suspected or reported);
- Sale, merger, or acquisition involving the ***FDR***;
- Significant changes in the management of the ***FDR***; and/or
- Changes in resources which impact CalOptima's and/or the ***FDR***'s operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The ***Compliance Officer***, or his/her ***designee***, shall submit regular reports of all monitoring, ***audit***, and corrective action activities to the ***Compliance Committee***. In instances where non-compliance is

identified, a ***Corrective Action Plan*** shall be developed by the ***FDR*** and reviewed and approved by the ***Compliance Officer***, or his/her ***dDesignee***. Every ***Corrective Action Plan*** is presented to the ***AOC*** for review. Supplemental and focused ***audits*** of ***FDRs***, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement ***sSanctions*** or require remediation by an ***FDR*** for failure to fulfill contractual obligations including development and implementation of a ***Corrective Action Plan***. Failure to cooperate with CalOptima in any manner may result in termination of the ***delegation*** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including ***pPolicies and pProcedures***, ***audit*** tools, and ***audit*** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated ***FDRs*** to monitor and track functions, performance, and ***audit*** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of ***audit*** tools;
- Implementation of a process for noticing ***FDRs*** and functional areas of ***Corrective Action Plans***;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding ***delegation*** standards, auditing, and monitoring ***FDR*** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of ***FDR*** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight ***audits*** completed within twelve (12) months; and
- ***Corrective Action Plans*** (***CAPs***) completed within the established timeframe.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's ***pPolicies and pProcedures***, CalOptima performs ***Participation Status*** Reviews by reviewing the OIG –LEIE, the GSA–SAM, and the ***DHCS*** Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure ***Board mMembers***, Employee***employees***, and/or ***FDRs*** are not excluded, or do not become excluded or precluded from participating in ***Federal and/or State health care programs***. ***Board mMembers***, Employee***employees***, and ***FDRs*** are required to disclose their ***pParticipation sStatus*** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when ***Board mMembers***, Employee***employees***, and ***FDRs*** receive notice of a suspension, preclusion, exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its ***First Tier Entities*** comply with ***Participation Status*** Review requirements with respect to their relationships with ***Downstream Entities***, including without limitation, the delegated credentialing and re-credentialing processes.

The ***Compliance Officer***, or his/her ***designee***, will review reports from Employee***employees*** responsible for conducting the ***Participation Status*** Reviews to ensure Employee***employees*** record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the ***Compliance Officer*** of affirmative findings of a person, or entity's, failure to meet the ***Participation Status*** Review requirements. If CalOptima learns that any prospective, or current, ***Board mMember***, Employee***employee***, or ***FDR*** has been proposed for exclusion, or excluded, or precluded, CalOptima will promptly remove him/her/the ***FDR*** from ***CalOptima's Programs programs*** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, exclusion, preclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies and/or contract terms. The ***Compliance Officer***, or his/her ***designee***, will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's ***Compliance Program*** and/or ***FWA*** issues, the ***Compliance Officer***, or his/her ***designee***, shall, upon promptly verifying the facts related to the violation or likely violation, notify the ***Compliance Committee***, as appropriate. The ***Compliance Committee*** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, ***sSanctions***, termination of any agreement and/or any other corrective action (including repayment of ***oOverpayments***) consistent with applicable ***pPolicies and pProcedures***, subject to consultation with legal counsel and/or notifying the ***Governing Body***, as appropriate;
- Implementing education and training programs for ***Board mMembers***, ~~Employee~~***employees***, and/or ***FDRs***, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's ***Compliance Plan***, ***Code of Conduct***, and/or relevant ***pPolicies and pProcedures*** in an effort to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the ***Compliance Officer*** and the ***Compliance Committee*** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable ***pPolicies and pProcedures*** after considering such recommendations. The ***Compliance Officer***, or his/her ***dDesignee***, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to ***DHCS*** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning ***fFraud*** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

activity indicates that ***f~~F~~raud*** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a ***f~~F~~raud*** alert is received, CalOptima shall review its ***delegation*** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the ***delegation*** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a ***f~~F~~raud*** alert. With the issuance of a ***f~~F~~raud*** alert, ***CMS*** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged ***f~~F~~raud*** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, ***DHCS*** Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of ***Federal and/or State health care programs*** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., ***f~~F~~raud*** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, ***DHCS***, ***CMS***, and ***CMS***' ***designee***, regarding monitoring of ***FDRs*** within CalOptima's network that ***DHCS***, or ***CMS***, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent ~~Fraud, Waste, and Abuse (~~***FWA***~~)~~ within a CalOptima program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of ***FWA*** activity. CalOptima shall assess all ***FDRs*** for potential ***o~~O~~verpayments*** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return ***o~~O~~verpayments*** consistent with applicable laws and regulatory guidance. Should revisions to reported data be required, CalOptima and/or FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of ***o~~O~~verpayment*** determinations to regulatory agencies, as required by law.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of ***FWA*** are components of CalOptima's ***Compliance Program***. ***FWA*** activities are implemented and overseen by CalOptima's ***Compliance Officer***, or his/her ***designee***, in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for ***FWA*** investigations. The ***Compliance Officer***, or his/her ***designee***, reports ***FWA*** activities to the CalOptima ***Compliance Committee***, CEO, the ***CalOptima Board***, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent, and remediate ***FWA***. In addition, CalOptima promptly investigates suspected ***FWA*** issues and implements disciplinary, or corrective, action to avoid recurrence of ***FWA*** issues. The objective of the ***FWA*** program is to ensure that the scope of benefits covered by the ***CalOptima pPrograms*** is appropriately delivered to ***mMembers*** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify ***FWA*** and promptly respond appropriately to such incidents of ***FWA***.

I.TRAINING

As detailed above, ***FWA*** training is provided to all ***Board mMembers*** and ~~Employee~~***employees*** as part of the overall compliance training courses in order to help detect, prevent, and remediate ***FWA***. ***FDRs*** are also required to complete ***FWA*** training, as described above. CalOptima's ***FWA*** training provides guidance to ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs*** on how to identify activities and behaviors that would constitute ***FWA*** and how to report suspected, or actual, ***FWA*** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual ***FWA***;
- Examples of the most common types of member ***FWA*** (see Appendix B, attached hereto and incorporated herein) and ***FDR FWA*** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify ***FWA*** in ***CalOptima~~'s PACE health P~~program~~s*** (*e.g.*, suspicious activities suggesting ~~PACE participants~~CalOptima members, or their family ***members***, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in ~~the PACE~~the ***CalOptima programs***, etc.);
- Information on how to identify potential prescription drug ***FWA*** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug

claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential ***FWA*** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for ***FDRs***, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the ***False Claims Act*** and CalOptima's requirement to train ~~Employee~~***employees*** and ***FDR***s on the ***False Claims Act*** and other applicable ***FWA*** laws.

CalOptima shall provide ***Board m~~M~~embers***, ~~Employee~~***employees***, ***FDRs***, and ***members*** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of ***FWA***. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. ***Members***, ***FDRs***, ~~Employee~~***employees***, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect ***FWA*** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record ***audits***;
- ***Member*** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- ~~Monitoring~~ Auditing and ***monitoring~~auditing~~ activities***;
- Monitoring external health care ***FWA*** cases and determining if CalOptima's ***FWA*** Program can be strengthened with information gleaned from the case activity; and/or

- Internal and external surveys, reviews, and ***audits***.

b. Data Analytics

CalOptima uses technology and data analysis to reduce ***FWA*** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect ***FDRs*** based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare-Medicaid ~~Advantage Part D~~ programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that Federal and State ~~Medicare~~ funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of ***FWA***.

The following trends will be reviewed and flagged for potential ***FWA***, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by ***members*** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;

- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or
- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected ***FWA***. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a ***member*** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of ***FWA***. The presence of several indicators may suggest ***FWA***, but further investigation is needed to determine if a suspicion of ***FWA*** actually exists. The following list

below highlights common industry indicators and red flags that are used to determine whether or not to investigate an ***FDR*** or their claim disposition:

- Claims that show any altered information (dates; codes; names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the ***member***/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the ***FWA*** database and a report is generated and submitted to the ***Compliance Officer***, ***Compliance Committee***, and CEO.

III.INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected ***FWA*** or detects ***FWA*** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an ***FDR*** to obtain relevant information;
- SIU, or a ***designee***, interviews the individual who reported the ***FWA***, affected ***members*** and/or ***FDRs***, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of ***FDR*** enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;

- After an allegation is logged into the Fraud Tracking ~~System~~Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database~~System~~ shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the ***Compliance Officer*** and ***Compliance Committee*** for discussion and approval.

IV.FINDINGS, RESPONSE, AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of ***FWA***, need for contract amendment, education and training requirement, recommendation of focused ***audits***, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential ***FWA*** issue has been identified, the SIU will track and trend the ***FWA*** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the ***Compliance Committee*** on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's ***p~~P~~olicies and p~~P~~rocedures***, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima ***p~~P~~olicies and p~~P~~rocedures***, CalOptima shall take appropriate disciplinary, or corrective, action against ***Board m~~M~~embers***, ~~Employee~~***employees***, and/or ***FDRs*** related to validated instances of ***FWA***. CalOptima will also assess ***FDRs*** for potential ***o~~O~~verpayments*** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the ***Compliance Committee***, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial ***sanctions***, regulatory reporting, ***Corrective Action Plans***, or termination of the ***delegation*** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first ***Compliance Committee*** following the date of identification of the suspected ***FWA***, the date of report to ***DHCS***, or the date of ***FWA*** substantiation by ***DHCS*** subsequent to the report. If vulnerability is identified through a single ***FWA*** incident, the correction action may be applied universally.

V.REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential ***FWA*** to appropriate regulatory agencies, or their designated program integrity contractors, including the ***CMS*** MEDIC, ***DHCS*** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. ***FDRs*** shall report ***FWA*** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to

timely report to applicable enforcement agencies. Significant program non-compliance, or suspected ***FWA***, should be reported to ***CMS*** and/or ***DHCS***, as soon as possible after discovery, but no later than ten (10) working days to ***DHCS*** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect, or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond ~~the~~ CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of ***FWA***;
- Patterns of ***FWA*** threatening the life, or well-being, of CalOptima ***members***; and/or
- Schemes with large financial risk to CalOptima, or its ***members***.

VI.ANNUAL EVALUATION

CalOptima's ***Compliance Committee*** shall periodically review and evaluate the ***FWA*** activities and its effectiveness as part of the overall ***Compliance Program*** ***audit*** ~~monitoring~~ and ***monitoring*** ~~***audit***~~ ***activities***. Revisions should be made based on industry changes, trends in ***FWA*** activities (locally and nationally), the OIG Work Plan, the CalOptima ***Compliance Plan***, and other input from applicable sources.

VII.RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of ***FWA*** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of ***FWA*** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII.CONFIDENTIALITY

CalOptima and its ***FDRs*** shall maintain all information associated with suspected, or actual, ***FWA*** in confidential files, which may only be released in accordance with applicable laws and CalOptima ***p*** ~~***P***~~***olicies and p*** ~~***P***~~***rocedures***. All participants and attendees of CalOptima's Quality Improvement Committee, ***Compliance Committee***, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the ***Compliance Program***, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the ***Compliance Program*** against the elements of an effective ***Compliance Program*** as recommended by OIG and required by ***CMS*** regulations. The following areas will be reviewed:

- ***Policies and procedures***;
- ***Compliance Officer*** and ***Compliance Committee***;
- Training and education of ***Board mMembers***, ~~Employee~~***employees***, and ***FDRs***;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing;
- ***Delegation*** oversight;
- Exclusion and preclusion screening process; and
- Prompt responses to detected offenses.

The ***Compliance Program*** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with ***sSenior mManagement***, the ***Compliance Committee***, and the ***CalOptima Board***. Updates to the ***Compliance Program*** will be based on the results of the evaluation and will be referred to the ***CalOptima Board*** for review and approval.

~~E.~~I. FILING SYSTEMS

The ***Compliance Officer***, or his/her ***designee***, shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

a. Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- ***Compliance Plan*** and any amendments;
- Any ***Compliance Program p~~P~~olicies and p~~P~~rocedures*** issued after the initiation of the ***Compliance Program***;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, ***Compliance Plan***, ***Code of Conduct*** and/or appointment of the ***Compliance Officer***;
- All non-privileged communications to the ***Compliance Officer*** (original);
- All ***Compliance Committee*** and ***CalOptima Board*** minutes in which compliance issues are discussed; and/or
- Any other written records of the ***AOC***, or other oversight activities (originals if generated by the ***Compliance Officer***).

b. Information and Education File

This file shall contain copies of the following (unless originals specified):

- ***FDR*** training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- ***Board m~~M~~ember*** and ~~Employee~~***employee*** training records, attestations, and attendance records are maintained by the Human Resources Department.
- Educational materials provided to ***Board m~~M~~embers***, ~~Employee~~***employees***, and ***FDRs***;
- Notices, ***f~~F~~raud*** alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

c. Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to compliance reports including reports to the Compliance and Ethics Hotline

and/or to the ***Compliance Officer*** (originals);

- Records relating to periodic monitoring and auditing of the ***Compliance Program*** (originals);
- Records relating to ***Board mMember***, ~~Employee~~***employee***, and ***FDR Participation Status*** Review or background checks (originals except where ***FDRs*** perform ***Participation Status*** Reviews);
- Records relating to established periodic monitoring mechanisms;
- All documents pertaining to the enforcement of the ***Compliance Program***, including, investigations and disciplinary and/or corrective actions; and/or
- All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

d. Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the ***Compliance Officer***, legal counsel, and the ***Compliance Committee***, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the ***Compliance Officer***;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning ***FDR delegation*** agreement interpretations and remedies available to CalOptima.

e. Document Retention

All of the documents to be maintained in the filing system described above shall be retained for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by ***HIPAA*** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) ***pPolicies and pProcedures*** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by ***HIPAA***; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under ***HIPAA***; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

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Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** 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 CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board mMembers, eEmployees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, eEmployees and cContractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, eEmployees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss eEmployee and cContractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, eEmployees, and cContractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Principle	Standard
	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, eEmployees and cContractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, eEmployees, and cContractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and cContractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of mMember care. Employees and cContractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and cContractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's fFacilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled mMembers. **Emergency Treatment** Employees and cContractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

Principle	Standard
	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its pPhysician gGroups, its hHealth nNetworks and tThird pParty aAdministrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the sState hHearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and cContractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima pPolicies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, eEmployees and cContractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, eEmployee, or cContractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima ~~or~~ about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and cContractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.
Public Integrity	**Public Records**

Principle	Standard
CalOptima and its Board members and eEmployees shall comply with laws and regulations governing public agencies.	CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima pPolicies. **Public Funds** CalOptima, its Board members, and eEmployees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and eEmployees shall comply with applicable law and CalOptima pPolicies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and eEmployees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code, Sections 54950 et seq.
Confidentiality Board members, eEmployees, and ecContractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, eEmployees and cContractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, eEmployees and cContractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files**

Principle	Standard
	Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, cContractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, cContractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, cEmployees, and cContractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, cEmployees, cContractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and cEmployees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima ~~Policies~~policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima ~~Policies~~ policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

Principle	Standard
	Third-Party Sponsored Events CalOptima's joint participation in cContractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Policies policies on this subject. In no event, shall CalOptima participate in any joint cContractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at cContractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Policiespolicies. **Provision of Gifts to Government Agencies** Board members, cEmployees, and cContractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and cEmployees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated cEmployees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and cEmployees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any cContractor, association of cContractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any cContractor or association of cContractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any cContractor or association of cContractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, eEmployees and cContractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, ~~national origin,~~ age, marital status, gender (which includes sex, gender identity, and gender expression), ~~gender,~~ sexual orientation, ~~gender identity,~~ health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, pPhysician gGroups, and hHealth nNetworks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that eEmployees, cContractors, pProviders, and sSuppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, eEmployees, and cContractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of eEmployees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, eEmployees and cContractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State hHealth cCare program. Employees, ~~and~~ individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its hHealth nNetworks, pPhysician gGroups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all eEmployees, cContractors, hHealth nNetworks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its mMembers have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the ~~Executive Director, Department of Compliance~~ Compliance Officer and/or their sSupervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and eEmployees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima ~~Policies~~ policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by ~~Legal~~ legal ~~Counsel~~counsel.
Compliance Program Reporting Board members, eEmployees, and cContractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, eEmployees and cContractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own ~~Policies~~ policies in accordance with CalOptima's reporting ~~Policies~~ policies and its Compliance Plan. Such reports may be made to a sSupervisor or ~~,~~ the ~~Executive Director, Office of~~ Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, ~~Policies~~ policies, and/or applicable statutes,

Principle	Standard
	regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's ~~Policies~~policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, c~~E~~mployees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima c~~E~~mployees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination ~~or~~, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, c~~E~~mployees, and c~~C~~ontractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable ~~Policies~~policies.

Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain cCovered sServices.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a ~~Covered~~ covered ~~Service~~ service for purposes other than the purpose for which it was described including use of such cCovered sService.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive cCovered sServices.	Hotline reports; internal reports; reports by hHealth nNetworks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping.	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription.	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for cCovered sServices that are substantially and demonstrably in excess of any individual's usual charges for such cCovered sServices.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for cCovered sServices that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for cCovered ~~Services~~ services that are in excess of the quantity that is mMedically nNecessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for cCovered sServices that are ~~that are~~ billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for cCovered sServices that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for cCovered sServices that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for cCovered sServices.	Member report; hotline report; oversight audits.
P09	Billing a member for cCovered sServices without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.

P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.
FDR FRAUD, WASTE OR PROGRAM ABUSE		**DETECTION CRITERIA Including but not limited to:**
P13	False certification of mMedical nNecessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate mMinimum sStandards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal mMember for sServices.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment-cCovered sServices that are not actually provided to ~~beneficiary~~member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a m~~M~~ember's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a m~~M~~ember's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a m~~M~~ember's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling m~~M~~ember's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for c~~C~~overed s~~S~~ervices that are not actually provided to the m~~M~~ember for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using m~~M~~ember's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima
AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.
I attended the annual Compliance Training Session on _____.

_____
Print Name

_____
Signature

_____
Date

RETURN TO THE COMPLIANCE OFFICER

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima pProgram, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fFraud, because the distinction between "fFraud" and "aAbuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means 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 (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director of Audit &and 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 Committeethe AOC charter.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code, Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima pProgram.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, and the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare

program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, eEmployees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and pPolicies and pProcedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, eEmployees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance ~~for compliance~~ and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code~~,~~ Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the

Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is 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 ("Downstream Entity") means any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima pProgram benefit, below the level of the arrangement between CalOptima and a fFirst tTier eEntity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Employee or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all sSenior mManagement, officers, mManagers, sSupervisors and other employed personnel, as well as temporary e Employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means 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 mMember under a CalOptima pProgram.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means 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.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Overpayment ("Overpayment") means a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its hHealth nNetworks for items or services furnished to mMembers. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State hHealth cCare pPrograms as provided in CalOptima pPolicies and pProcedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, eEmployees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State hHealth cCare pPrograms.

Policies and Procedures ("Policies and Procedures") means CalOptima's written pPolicies and pProcedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means 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 mMembers 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 ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or

its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima pPrograms.

Senior Management ("Senior Management") means any cEmployee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.

Sub-delegation ("Sub-delegation") means the process by which a fFirst tTier cEntity expressly grants, by formal agreement, to a dDownstream cEntity the authority to carry out one or more functions that would otherwise be required to be performed by the fFirst tTier cEntity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an cEmployee in a position representing CalOptima who has one (1) or more cEmployees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima cEmployee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a cContractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima pProgram. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Orange County Health Authority

dba CalOptima

2019 Compliance Plan

(Revised December 2018)

Document maintained by:
Silver Ho
CalOptima Compliance Officer

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A. OVERVIEW OF THE COMPLIANCE PROGRAM

The Orange County Health Authority, dba CalOptima, is committed to conducting its operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and other ***CalOptima programs***.*

CalOptima's compliance commitment encompasses its own internal operations, as well as its oversight and monitoring responsibilities related to CalOptima's ***First Tier***, ***Downstream***, and ***Related Entities*** (***FDRs***), such as ***health networks***, physician groups, ***participating providers and suppliers***, pharmacy benefit manager (PBM), and consultants. The term ***FDR*** is used in this document to refer to CalOptima's delegated subcontractors that perform administrative functions and/or provide health care services that CalOptima is required to perform and/or provide under its state and federal contracts with the ***Centers for Medicare & Medicaid Services*** (***CMS***) and the ***Department of Health Care Services*** (***DHCS***). Such persons/entities, referred to as ***FDR*** herein, include those that directly contract with CalOptima and those that are ***Downstream*** or ***Related Entities*** (i.e., subcontracts) with CalOptima's ***First Tier Entities***.

CalOptima has developed a comprehensive ***Compliance Program*** applicable to all of CalOptima's programs, including, but not limited to, its Medi-Cal Program, its Medicare Advantage Prescription Drug Program (MA-PDP referred to as "OneCare"), its Medicare-Medicaid Plan (MMP referred to as "OneCare Connect"), PACE, and MSSP. The ***Compliance Program*** incorporates all of the elements of an effective ***Compliance Program*** as recommended by the ***Office of the Inspector General*** (***OIG***) and required by ***CMS*** regulations. The ***Compliance Program*** is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk. CalOptima requires that CalOptima ***Board members***, ***employee***s, and ***FDRs*** conduct themselves in accordance with the requirements of CalOptima's ***Compliance Program***.

B. THE COMPLIANCE PLAN

This ***Compliance Plan*** sets forth CalOptima's commitment to legal and ethical conduct by establishing compliance activities, along with CalOptima principles and standards, to efficiently monitor adherence to all applicable laws, regulations, and guidelines. The ***Compliance Plan*** addresses the fundamental elements of an effective ***Compliance Program*** and identifies how CalOptima is implementing each of the fundamental elements of an effective ***Compliance Program*** in its operations to meet its contractual, legal, and regulatory obligations. Moreover, the ***Compliance Plan*** is designed to provide guidance and to ensure that CalOptima's operations and the practices of its ***Board members***, ***employees***, and ***FDRs*** comply with contractual requirements, ethical standards, and applicable law.

This ***Compliance Plan*** is adopted by the ***Governing Body***. It was developed and is managed by the ***Executive Director of Compliance*** (referred to hereinafter as the "***Compliance Officer***") with the ***Compliance Committee***. Because the complex laws governing CalOptima and its programs are constantly evolving, the ***Compliance Plan*** may be revised and updated from time to time to respond to changes in the law and/or to reflect improvements in CalOptima's operations and processes.

Board members, ***employees***, and ***FDRs*** are expected to review and adhere to the requirements and standards set forth in the ***Compliance Plan***, the ***Code of Conduct***, and all related ***policies and procedures***, as may be amended. Furthermore, ***Board members***, ***employees***, and ***FDRs*** are expected to be familiar with the contractual, legal, and regulatory requirements pertinent to their respective roles and responsibilities. If a ***Board member***, ***employee***, and/or ***FDR*** has/have any questions about the application, or implementation, of this ***Compliance Plan***, or questions related to the ***Code of Conduct*** or CalOptima ***policies and procedures***, he or she should seek guidance from the ***Compliance Officer*** and/or the CalOptima Office of Compliance.

I.WRITTEN STANDARDS

To demonstrate CalOptima's commitment to complying with all applicable federal and state standards and to ensure a shared understanding of what ethical and legal standards and requirements are expected of ***Board members***, ***employees***, and ***FDRs***, CalOptima develops, maintains, and distributes its written standards in the form of this ***Compliance Plan***, a separate ***Code of Conduct***, and written ***policies and procedures***.

a. Compliance Plan

As noted above, this ***Compliance Plan*** outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to CalOptima ***Board members***, ***employees***, and ***FDRs***. This ***Compliance Plan*** also includes a comprehensive section articulating CalOptima's commitment to preventing ***Fraud***, ***Waste***, & ***Abuse*** (***FWA***), and setting forth guidelines and procedures designed to detect, prevent, and remediate ***FWA*** in the administration of ***CalOptima programs***. The ***Compliance Plan*** is available on CalOptima's external website for ***Board members*** and ***FDRs*** as well as on CalOptima's internal intranet site, referred to as InfoNet, accessible to all ***employees***.

b. Policies and Procedures

CalOptima also developed written ***policies and procedures*** to address specific areas of CalOptima's operations, compliance activities, and ***FWA*** prevention, detection, and remediation to ensure CalOptima can efficiently monitor adherence to all applicable laws, regulations, and guidelines. These policies are designed to provide guidance to ***Board members***, ***employees***, and ***FDRs*** concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. ***Board members***, ***employees***, and ***FDRs*** are expected to be familiar with the ***policies and procedures*** pertinent to their respective roles and responsibilities, and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The ***Compliance Officer***, or his/her ***designee***, will ensure that ***Board members***, ***employees***, and ***FDRs*** are informed of applicable policy requirements, and that such dissemination of information is documented and retained in accordance with applicable record retention standards.

The ***policies and procedures*** are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima's ***policies and procedures*** are reviewed and approved by CalOptima's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, meets regularly to review and approve proposed changes and additions to CalOptima's ***policies and procedures***. ***Policies and procedures*** are available on CalOptima's internal website and Compliance 360, a separate web portal accessible to ***Board members***, ***employees***, and ***FDRs***. ***Board members***, ***employees***, and ***FDRs*** receive notice when ***policies and procedures*** are updated via a monthly memorandum.

c. Code of Conduct

Finally, the ***Code of Conduct*** is CalOptima's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima. The objective of the ***Code of Conduct*** is to articulate compliance expectations and broad principles that guide CalOptima ***Board members***, ***employees***, and ***FDRs*** in conducting their business activities in a professional, ethical, and lawful manner. The ***Code of Conduct*** is a separate document from the ***Compliance Plan*** and can be found in Appendix A. The ***Code of Conduct*** is approved by CalOptima's Board of Directors and distributed to ***Board members***, ***employees***, and ***FDRs*** upon appointment, hire, or the commencement of the contract, and annually thereafter. New ***Board members***, ***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt and review of the ***Code of Conduct*** within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

II.OVERSIGHT

The successful implementation of the ***Compliance Program*** requires dedicated commitment and diligent oversight throughout CalOptima's operations, including, but not limited to, key roles and responsibilities by CalOptima's Board, the ***Compliance Officer***, the ***Compliance Committee***, the ***Audit & Oversight Committee***, and ***senior management***.

a. Governing Body

The ***CalOptima Board*** of Directors, as the ***Governing Body***, is responsible for approving, implementing, and monitoring a ***Compliance Program*** governing CalOptima's operations. The ***CalOptima Board*** delegates the ***Compliance Program*** oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the ***Compliance Officer***. The ***Compliance Officer*** is an ***employee*** of CalOptima, who handles compliance oversight and activities full-time. The ***Compliance Officer***, in conjunction with the ***Compliance Committee***, are both accountable for the oversight and reporting roles and responsibilities as set forth in this ***Compliance Plan***. However, the ***CalOptima Board*** remains accountable for ensuring the effectiveness of the ***Compliance Program*** within CalOptima and monitoring the status of the ***Compliance Program*** to ensure its efficient and successful implementation.

To ensure the ***CalOptima Board*** exercises reasonable oversight with respect to the implementation and effectiveness of CalOptima's ***Compliance Program***, the ***CalOptima Board***:

- Understands the content and operation of CalOptima's ***Compliance Program***;
- Approves the ***Compliance Program***, including this ***Compliance Plan*** and the ***Code of Conduct***;
- Requires an effective information system that allows it to properly exercise its oversight role and be informed about the ***Compliance Program*** outcomes, including, but not limited to, results of internal and external ***audits***;
- Receives training and education upon appointment, and annually thereafter, concerning the structure and operation of the ***Compliance Program***;

- Remains informed about governmental compliance enforcement activity, such as Notices of Non-Compliance, ***Corrective Action Plans***, Warning Letters, and/or ***sanctions***;
- Receives regularly scheduled, periodic updates from CalOptima's ***Compliance Officer*** and ***Compliance Committee***, including, but not limited to, monthly reports summarizing overall compliance activities and any changes that are recommended;
- Receives timely written notification and updates on urgent compliance issues that require engagement and action;
- Convenes formal ad hoc and closed session discussions for significant and/or sensitive compliance matters, to the extent permitted by applicable law; and
- Reviews the results of performance and effectiveness assessments of the ***Compliance Program***.

The ***CalOptima Board*** reviews the measurable indicators of an effective ***Compliance Program*** and remains appropriately engaged in overseeing its efficient and successful implementation; however, the ***CalOptima Board*** delegates several compliance functions and activities as described in the following subsections.

b. Executive Director of Compliance (Compliance Officer)

The ***Executive Director of Compliance*** serves as the ***Compliance Officer*** who coordinates and communicates all assigned compliance activities and programs, as well as plans, implements, and monitors the day-to-day activities of the ***Compliance Program***. The ***Compliance Officer*** reports directly to the CEO and the ***Compliance Committee*** on the activities and status of the ***Compliance Program***. The ***Compliance Officer*** has authority to report matters directly to the ***CalOptima Board*** at any time. Furthermore, the ***Compliance Officer*** ensures that CalOptima meets all state and federal regulatory and contractual requirements.

The ***Compliance Officer*** interacts with the ***CalOptima Board***, CEO, CalOptima's executive and departmental management, ***FDRs***, legal counsel, state and federal representatives, and others as required. In addition, the ***Compliance Officer*** supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, Special Investigations, Privacy, ***FDR*** and internal oversight, ***policies and procedures***, and training on compliance activities.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Officer***, and/or his/her ***designee***(s):

- Chair the ***Compliance Committee***, which shall meet no less than quarterly and assists the ***Compliance Officer*** in fulfilling his/her responsibilities;
- Ensure that the ***Compliance Program***, including this ***Compliance Plan*** and ***policies and procedures***, are developed, maintained, revised, and updated, annually, or as needed, based on changes in CalOptima's needs, regulatory requirements, and applicable law and distributed to all affected ***Board members***, ***employees***, and ***FDRs***, as appropriate;
- Oversee and monitor the implementation of the ***Compliance Program***, and provide regular reports no less than quarterly to the ***CalOptima Board*** and CEO summarizing all efforts,

including, but not limited to, the ***Compliance Committee***'s efforts to ensure adherence to the ***Compliance Program***, identification and resolution of suspected, detected, or reported instances of non-compliance, and CalOptima's compliance oversight and ***audit*** activities;

- Maintain the compliance reporting mechanisms and manage inquiries and reports from CalOptima's Compliance and Ethics Hotline in accordance with specified protocols, including, but not limited to, maintenance of documentation for each report of potential non-compliance or potential ***FWA*** received from any source through any reporting method;
- Design, coordinate, and/or conduct regular internal ***audits*** to ensure the ***Compliance Program*** is properly implemented and followed, in addition to verifying all appropriate financial and administrative controls are in place;
- Develop and implement an annual schedule of ***Compliance Program*** activities for each of CalOptima's programs, and regularly report CalOptima's progress in implementing those plans to the appropriate Board Committee and/or to the Board of Directors;
- Serve as a liaison between CalOptima and all applicable state and federal agencies for non-compliance and/or ***FWA*** issues, including facilitating any documentation or procedural requests by such agency(s);
- Oversee and monitor all compliance investigations, including investigations performed by CalOptima's regulators (e.g., ***DHCS*** and ***CMS***) and consult with legal counsel, as necessary;
- Create and coordinate educational training programs and initiatives to ensure that the ***CalOptima Board***, ***employees***, and ***FDRs*** are knowledgeable about CalOptima's ***Compliance Program***, including the ***Code of Conduct***, ***policies and procedures***, and all current and emerging applicable statutory and regulatory requirements;
- Timely initiate, investigate, and complete risk assessments and related activities, and direct and implement appropriate ***Corrective Action Plans***, ***sanctions***, and/or other remediation, including, but not limited to, collaboration with the Human Resources Department to ensure consistent, timely, and effective disciplinary standards are followed; and
- Coordinate with CalOptima departments and ***FDRs*** to ensure exclusion and preclusion screening (including through the OIG List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), Medi-Cal Suspended & Ineligible (S&I) Provider List, and the CMS Preclusion List) has been conducted and acted upon, as appropriate, in accordance with regulatory and contractual requirements.

c. Compliance Committee

The ***Compliance Committee***, chaired by the ***Compliance Officer***, is composed of CalOptima's ***senior management*** and operational staff, as designated by the CEO. The members of the ***Compliance Committee*** serve at the discretion of the CEO and may be removed, or added, at any time. The role of the ***Compliance Committee*** is to implement and oversee the ***Compliance Program*** and to participate in carrying out the provisions of this ***Compliance Plan***. The ***Compliance Committee*** meets at least on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the ***Compliance Program***.

The ***CalOptima Board*** delegates the following responsibilities to the ***Compliance Committee***:

- Maintain and update the ***Code of Conduct*** consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the ***CalOptima Board***;
- Maintain written notes, records, correspondence, or minutes (as appropriate) of ***Compliance Committee*** meetings reflecting reports made to the ***Compliance Committee*** and the ***Compliance Committee***'s decisions on the issues raised (subject to all applicable privileges);
- Review and ***Monitor*** the effectiveness of the ***Compliance Program***, including ***Monitoring*** key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;
- Analyze applicable federal and state program requirements, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the ***Compliance Officer*** to ensure the adequacy of the ***Compliance Program***;
- Review, approve, and/or update ***policies and procedures*** to ensure the successful implementation and effectiveness of the ***Compliance Program*** consistent with regulatory, legal, and contractual requirements;
- Recommend and monitor the development of internal systems and controls to implement CalOptima's standards and ***policies and procedures*** as part of its daily operations;
- Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the ***Compliance Officer*** accordingly;
- Develop and maintain a reporting system to solicit, evaluate, and respond to complaints and problems;
- Review and address reports of ***monitoring*** and auditing of areas in which CalOptima is at risk of program non-compliance and/or potential ***FWA***, and ensure ***CAPs*** and ICAPs are implemented and Monitored for effectiveness;
- Suggest and implement all appropriate and necessary actions to ensure that CalOptima and its ***FDRs*** conduct activities and operations in compliance with the applicable law and regulations and sound business ethics; and
- Provide regular and ad-hoc status reports of compliance with recommendations to the ***CalOptima Board of Directors***.

d. Audit & Oversight Committee (AOC)

The ***Audit & Oversight Committee*** (***AOC***) is a subcommittee of the ***Compliance Committee*** and is co-led by the Director(s) of Audit & Oversight. The ***AOC*** is responsible for overseeing the delegated and internal activities of CalOptima. The ***Compliance Committee*** has final approval authority for any delegated and internal activities. Committee members include representatives from CalOptima's departments as provided for in CalOptima Policy HH.4001Δ: Audit & Oversight Committee. In addition to the monthly scheduled meetings, the ***AOC*** may conduct ad hoc meetings either in-person or via teleconference, as needed. All materials requiring action by the ***AOC*** are approved by the majority of a quorum of the ***AOC***. A quorum is defined as one (1) over fifty percent (50%). The ***AOC*** may approve and/or implement ***Corrective Action Plans*** (***CAPs***); however, recommendations for ***FDR*** sanctioning and/or de-***delegation*** are submitted to the ***Compliance Committee*** for final approval. The ***AOC*** also contributes to external reviews and accreditation ***audits***, such as the

National Committee for Quality Assurance (***NCQA***).

Responsibilities of the ***AOC*** with regard to ***FDRs*** include:

- Annual review, revision, and approval of the ***audit*** tools;
- Review findings of the readiness assessment to evaluate a potential ***FDR***'s ability to perform the delegated function(s);
- Review and approve potential ***FDR*** entities for ***delegation*** of functions;
- Ensure written agreements with each delegated ***FDR*** clearly define and describe the delegated activities, responsibilities, and reporting requirements of all parties consistent with applicable laws, regulations, and contractual obligations;
- Conduct formal, ongoing evaluation and monitoring of ***FDR*** performance and compliance through review of periodic reports submitted, complaints/grievances filed, and findings of the annual onsite ***audit***;
- Ensure all ***Downstream*** and ***Related Entities*** are monitored in accordance with CalOptima oversight procedures;
- Ensure that formal risk assessment is conducted on an annual basis, and update as needed, on an ongoing basis;
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues;
- Propose ***sanctions***, subject to the ***Compliance Committee***'s approval, if an ***FDR***'s performance is substandard and/or violates the terms of the applicable agreement; and
- Review and initiate recommendations, such as termination of ***delegation***, to the ***Compliance Committee*** for unresolved issues of compliance.

Responsibilities of the ***AOC*** with regard to internal business functions include:

- Annual review, revision, and approval of the audit work plan and ***audit*** tools;
- Conduct formal, ongoing evaluation and monitoring of internal business areas' performance and compliance through review of periodic reports submitted, ongoing monitoring, and findings of the annual ***audit***;
- Conduct formal risk assessment on an annual basis, and update as needed, on an ongoing basis; and
- Initiate and manage ***Corrective Action Plans*** (***CAPs***) for compliance issues.

e. Senior Management

The CEO and other executive management of CalOptima shall:

- Ensure that the ***Compliance Officer*** is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective ***Compliance Program***;

- Receive periodic reports from the ***Compliance Officer*** of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies; and
- Be advised of all governmental compliance and enforcement findings and activity, including ***audit*** findings, notices of non-compliance, and formal enforcement actions, and participate in corrective actions and responses, as appropriate.

III. TRAINING

Education and training are critical elements of the ***Compliance Program***. CalOptima requires that all ***Board members***, ***employees***, and ***FDRs*** complete training upon appointment, hire, or commencement of contract, as applicable, and on an annual basis thereafter. Required courses cover CalOptima's ***Code of Conduct***, compliance obligations, and relevant laws, and ***FWA***, as applicable. Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima's departments and its programs, which may include, but is not limited to, the fundamentals of managing seniors and people with disabilities (SPD) and cultural competency.

CalOptima utilizes state of the art web-based training courses that emphasize CalOptima's commitment to the ***Compliance Program***, and which courses are updated regularly to ensure that ***employees*** are kept fully informed about any changes in procedures, regulations, and requirements. Training may be conducted using new technology resources if materials meet the needs of the organization. The ***Compliance Officer,*** or his/her ***designee*** is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/***FDR***'s completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by law. The ***Compliance Officer*** and the CalOptima management staff are responsible for ensuring that ***Board members***, ***employees***, and ***FDRs*** complete training on an annual basis.

a. Code of Conduct

CalOptima's training program includes the distribution of CalOptima's ***Code of Conduct*** to ***Board members***, ***employees***, and ***FDRs***. ***Board members***, ***employees***, and ***FDRs*** are required to sign an attestation acknowledging receipt, review, and understanding of the ***Code of Conduct*** within ninety (90) calendar days of their appointment, date of hire, or commencement of the contract, and annually thereafter. Completion and attestation of such review of the ***Code of Conduct*** is a condition of continued appointment, employment, or contract services. Signed attestations are maintained in each individual's personnel file, as required by law.

b. Mandatory Training Courses (Compliance Oversight, FWA, and HIPAA)

CalOptima requires ***Board members***, ***employees***, and ***FDRs***, regardless of role or position with CalOptima, to complete mandatory compliance training courses. Mandatory courses may include, but are not limited to: the fundamentals of the ***Compliance Program***; ***FWA*** training; Health Insurance Portability and Accountability Act of 1996 (***HIPAA***) privacy and security requirements; ethics; and a high-level overview of the Medicare and Medi-Cal Programs. Detailed information about state and federal false claims acts and whistleblower protections as provided in CalOptima Policy HH.5004Δ: False Claims Act Education shall be included in the mandatory courses. CalOptima's training courses cover CalOptima's commitment to compliance with federal and state laws and regulations, contractual obligations, internal policies, and ethics. Elements of the ***Compliance Program*** are highlighted, including, but not limited to, an emphasis on CalOptima's requirement to and different means to report suspected or actual non-compliance, violations, and/or ***FWA*** issues, along with CalOptima's policy on confidentiality, anonymity, and non-retaliation for such reporting. CalOptima's ***HIPAA*** privacy and security training course covers the administrative,

technical, and physical safeguards necessary to secure ***members***' protected health information (PHI) and personally identifiable information (PII).

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the ***Compliance Program*** requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each ***employee***. ***Board members*** and ***FDRs*** are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter. Some ***FDRs*** may be exempt or deemed to have met the ***FWA*** training and education requirement if the ***FDR*** has met the ***CMS*** requirements, the applicable certification requirements and attests to complying with the standards, or through enrollment into the Medicare program, or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Completion of the training courses are documented electronically, and records of completion are maintained for each individual as required by law.

c. Additional Training

The Office of Compliance may provide additional training opportunities throughout the year focused on essential elements of the ***Compliance Program***. These training opportunities are available to ***managers*** and ***employees*** depending on their respective roles or positions within or with CalOptima's departments and its programs and their involvement in CalOptima's oversight responsibilities. For these training courses, information is presented in a "train the trainer" format, providing ***managers*** the tools and resources to train and share the information with ***employees*** in their respective departments. If additional training related to ***FWA*** is required, the ***Compliance Officer,*** or his/her ***designee,*** will develop relevant materials.

Employees have access through CalOptima's internal intranet website (referred to as the "InfoNet") to CalOptima's ***policies and procedures*** governing the ***Compliance Program*** and pertinent to their respective roles and responsibilities. ***Employees*** may receive such additional compliance training as is reasonable and necessary based on changes in job descriptions/duties, promotions, and/or the scope of their job functions.

Board members receive a copy of the ***Compliance Plan***, ***Code of Conduct***, and ***policies and procedures*** pertinent to their appointment as part of orientation within ninety (90) calendar days of their appointment to the ***CalOptima Board***. ***Board members*** may receive additional compliance training related to the ***CalOptima Board***'s role in overseeing and ensuring organizational compliance with CalOptima's ***Compliance Program***.

The ***Code of Conduct*** and ***policies and procedures*** pertinent to their engagement with CalOptima, if directly engaged by CalOptima, are made available to ***FDRs*** upon commencement of the ***FDR*** contract. ***FDRs*** are required to disseminate copies of the ***Code of Conduct*** and ***policies and procedures*** to their ***employees***, agents, and/or ***Downstream Entities***. CalOptima may also develop compliance training and education presentations and/or roundtables for specified ***FDRs***.

IV. LINES OF COMMUNICATION AND REPORTING

a. General Compliance Communication

CalOptima regularly communicates the requirements of the ***Compliance Program*** and the importance of performing individual roles and responsibilities in compliance with applicable laws, contractual obligations, and ethical standards. CalOptima utilizes various methods and forms to communicate general information, statutory or regulatory updates, process changes, updates to ***policies and procedures***, contact information for the ***Compliance Officer***, relevant federal and state ***fraud*** alerts and policy letters, pending/new legislation reports, and advisory bulletins from the ***Compliance Officer*** to CalOptima ***Board members***, ***employees***, ***FDRs***, and ***members***, including, but not limited to:

- Presentations and Updates at Meetings – CalOptima periodically holds and utilizes in-person and conference call meetings with the ***CalOptima Board***, ***FDRs***, ***employees***, individual CalOptima departments, and ***members***.
- Compliance 360 – CalOptima maintains an internal and external website and portal referred to as Compliance 360, accessible to ***Board members***, ***employees***, and ***FDRs***, which contains CalOptima's updated ***policies and procedures***.
- Newsletters or Mailed Notices – CalOptima develops, and where appropriate, translates, publications and/or notices, to ***Board members***, ***employees***, ***FDRs***, and ***members***.
- Electronic Mail – The CEO, ***Compliance Officer***, or their respective ***designee***, periodically sends out email communications and/or alerts to ***Board members***, ***employees***, ***FDRs***, and/or ***members***, as applicable.
- CalOptima's Internal Intranet Website – CalOptima maintains an internal intranet website, referred to as InfoNet, where CalOptima posts applicable updates and notices to ***employees***.
- CalOptima's Compliance Internal Website – The Office of Compliance maintains an internal department website accessible to CalOptima ***employees*** to communicate different Compliance initiatives, notices, key documents and forms, and updates to the ***Compliance Program***, ***Code of Conduct***, and/or ***policies and procedures***.
- Postings – The Office of Compliance posts information on how to report potential issues of non-compliance and ***FWA*** throughout CalOptima's facilities, including, but not limited to, break rooms, which are accessible to CalOptima ***employees***.
- Written Reports – The ***Compliance Officer***, in coordination with the CEO and ***Compliance Committee***, prepares written monthly reports concerning the status of the ***Compliance Program*** to be presented to the ***CalOptima Board***.
- Direct Contact with the ***Compliance Officer*** - ***Board members***, ***employees***, and ***FDRs*** can obtain additional compliance information directly from the ***Compliance Officer***. Any questions, which cannot be answered by the ***Compliance Officer***, shall be referred to the ***Compliance Committee***.

b. Reporting Mechanisms

CalOptima ***Board members***, ***employees***, and ***FDRs*** have an affirmative duty and are directed in CalOptima's ***Code of Conduct*** and ***policies and procedures*** to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery. Failure by ***Board members***, ***employees***, and/or ***FDRs*** to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports may constitute grounds for disciplinary action, up to and including, recommendation for removal from appointment, termination of employment, or termination of an ***FDR*** contract, where appropriate.

CalOptima has established multiple reporting mechanisms to receive, record, and respond to compliance questions, potential non-compliance issues and/or ***FWA*** incidents or activities. These reporting systems, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). Reminders and instructions on how to report compliance and ***FWA*** issues are also provided to ***Board members***, ***employees***, ***FDRs***, and ***members*** in newsletters, on CalOptima's website, in trainings, on posters and at meetings. CalOptima maintains and supports a non-retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or ***FWA***.

Upon receipt of a report through one (1) of the listed mechanisms, the ***Compliance Officer***, or his/her ***designee,*** shall follow appropriate ***policies and procedures*** to promptly review, investigate, and resolve such matters. The ***Compliance Officer,*** or his/her ***designee,*** shall monitor the process for follow-up communications to persons submitting reports or disclosures through these reporting mechanisms and shall ensure documentation concerning such reports is maintained according to all applicable legal and contractual requirements.

1. *Report Directly to a Supervisor or Manager*

CalOptima ***employees*** are encouraged to contact their immediate ***supervisor***, or ***manager***, when non-compliant activity is suspected, or observed. A report should be made immediately upon suspecting or identifying the potential or suspected non-compliance, or violation. The ***supervisor***, or ***manager***, will promptly escalate the report to the ***Compliance Officer*** for further investigation and reporting to the CalOptima ***Compliance Committee***. If an ***employee*** is concerned that his/her ***supervisor*** or ***manager*** did not adequately address his/her report or complaint, the ***employee*** may go directly to the ***Compliance Officer***, or the CEO.

2. *Call the Compliance and Ethics Hotline*

CalOptima maintains an easily accessible Compliance and Ethics Hotline, available twenty-four (24) hours a day, seven (7) days a week, with Spanish and English capability, in which CalOptima may receive anonymous issues on a confidential basis. ***Members*** are encouraged to call the Compliance and Ethics Hotline if they have identified potential non-compliant activity, or ***FWA*** issues. The Compliance and Ethics Hotline information is as follows:

TOLL FREE COMPLIANCE and ETHICS HOTLINE
(877) 837-4417

Calls or issues reported through the Compliance and Ethics Hotline are received, logged into a database, and investigated by the Regulatory Affairs & Compliance Department. No disciplinary

action will be taken against individuals making good-faith reports. Every effort will be made to keep reports confidential to the extent permitted by law. The process for reporting suspected violations to the Compliance and Ethics Hotline is part of the education and/or orientation for all ***Board members***, ***employees***, ***FDRs***, and ***members***. ***Members*** also have access to the ***Compliance Officer*** through the Compliance and Ethics Hotline and/or the right to contact the OIG Compliance Hotline directly.

3. *Report Directly to the Compliance Officer*

The ***Compliance Officer*** is available to receive reports of suspected or actual compliance violations, or ***FWA*** issues, on a confidential basis (to the extent permitted by applicable law or circumstances) from ***Board members***, ***employees***, ***FDRs*** and ***members***. The ***Compliance Officer*** may be contacted by telephone, written correspondence, email, or by a face-to-face appointment. ***FDRs*** are generally contractually obligated to report suspected ***fraud*** and ***abuse*** to CalOptima pursuant to regulatory and contractual requirements.

4. *Report Directly to Office of Compliance*

Reports may be made directly to CalOptima's Office of Compliance via mail, email, or through the Compliance and Ethics Hotline for confidential reporting. Emails can be sent to Compliance@caloptima.org. Mail can be sent to:

CalOptima
ATTN: Compliance Officer
505 City Parkway West
Orange, CA, 92868

5. *Confidentiality and Non-Retaliation*

Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or ***FWA***, issues in good faith. This non-retaliation policy extends to reports received from ***FDRs*** and ***members***. CalOptima's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima InfoNet and website, as well as sending periodic member notifications.

CalOptima also takes violations of CalOptima's non-retaliation policy seriously, and the ***Compliance Officer*** will review and enforce disciplinary and/or other ***Corrective Action Plans*** for violations, as appropriate, with the approval of the ***Compliance Committee***.

V.ENFORCEMENT AND DISCIPLINARY STANDARDS

Board members, ***employees***, and ***FDRs*** are provided copies of CalOptima's ***Code of Conduct*** and the ***Compliance Plan*** and have access on CalOptima's internal and external website to applicable ***policies and procedures***, including, but not limited to, CalOptima Policy GA.8022: Performance and Behavior Standards and Office of Compliance Policies addressing ***Corrective Action Plans*** and ***sanctions***. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance or unethical behavior is confirmed, and appropriate disciplinary and/or corrective action is implemented to address improper conduct, activity, and/or behavior.

a. Conduct Subject to Enforcement and Discipline

Board members, ***employees***, and ***FDRs*** are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima's standards, requirements, or applicable laws as specified and detailed in the ***Compliance Program*** documents and related ***policies and procedures***, including CalOptima Policy GA.8022: Performance and Behavior Standards, as applicable. ***Board members***, ***employees***, and ***FDRs*** may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima's ***Compliance Program*** and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements;
- Conduct that results in a violation, or violations, of any other federal or state laws or contractual requirements relating to participation in ***Federal and/or State health care programs***;
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, ***policies and procedures*** and/or contracts; or
- Failure to report violations or suspected violations of the ***Compliance Program***, or applicable laws, or to report suspected or actual ***FWA*** issues to an appropriate person through one (1) of the reporting mechanisms.
- Conduct that violates ***HIPAA*** and other privacy laws and/or CalOptima's ***HIPAA*** privacy and security policies, including actions that harm the privacy of ***members***, or the CalOptima information systems that store member data.

b. Enforcement and Discipline

CalOptima maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima. The standards established in the ***Compliance Program*** shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, ***sanctions***, and/or termination, depending on the nature and severity of the conduct, or behavior. ***Board members*** may be subject to removal, ***employees*** are subject to discipline, up to and including termination, and ***FDRs*** may be sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima to civil, criminal, or administrative ***sanctions*** and/or penalties.

Further violations could lead to suspension, preclusion, or exclusion, from participation in ***Federal and/or State health care programs***.

CalOptima ***employees*** shall be evaluated annually based on their compliance with CalOptima's ***Compliance Program***. Where appropriate, CalOptima shall promptly initiate education and training to correct identified problems, or behaviors.

VI.MONITORING, AUDITING, AND IDENTIFICATION OF RISKS

Activities associated with monitoring and auditing are identified through a combination of activities: risk assessments, Audit & Oversight and ***Compliance Committee*** discussions and decisions, and internal and external reporting. Through monitoring, auditing, and identification of risks, CalOptima can prevent, detect, and correct non-compliance with applicable federal and/or state requirements.

a. Risk Assessment

The ***Compliance Officer,*** or his/her ***designee,*** will collaborate with the ***Compliance Committee*** to identify areas of focus for monitoring and auditing potential non-compliant activity and ***FWA*** issues. A Compliance Risk Assessment will be performed no less than annually, and as needed, to evaluate the current status of CalOptima's operational areas as well as the operations of ***FDRs***. Operations and processes will be evaluated based on: (1) deficiencies found by regulatory agencies; (2) deficiencies found by internal and external ***audit*** and ***monitoring*** reports; (3) the institution of new or updated procedures; (4) cross departmental interdependencies; and (5) the effect on the beneficiary experience. The Readiness Checklist established by ***CMS*** and the OIG Work Plan shall be used as resources to evaluate operational risks.

The ***Compliance Officer,*** or his/her ***designee,*** will work with the Chief Operating Officer, or his/her ***designee***, in each operational area, to answer the questions associated with each process and to continually examine and identify potential risk areas requiring monitoring and auditing. Those operational areas determined to be high risk may be subject to more frequent monitoring and auditing, as well as additional reporting requirements. The risk assessment process will be managed by the ***Compliance Officer***, or his/her ***designee***, and presented to the ***AOC***, and subsequently to the ***Compliance Committee***, for review and approval. Monitoring plans will be developed in collaboration with the operational areas, and focused ***audits*** may be scheduled based on the results of the ongoing monitoring and respective risk score.

The risk assessment shall also be updated as processes change, or are identified as being deficient.

b. Monitoring and Auditing

CalOptima conducts both internal and external routine auditing and ***monitoring activities*** to test and confirm compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima ***policies and procedures*** to protect against non-compliance and potential ***FWA*** in ***CalOptima programs***. CalOptima and FDRs shall comply with applicable data certification requirements, including, without limitation, 42 C.F.R. §§ 438.604 and 438.606. ***Monitoring activities*** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. An ***audit*** is 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. As part of the monitoring process, CalOptima has created a dashboard, which is a monitoring tool to track key metrics, including, but not limited to, coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer

service, transition of coverage (TOC), and claims. The dashboard will be used to communicate results associated with monitoring operations and outcomes and to identify areas in need of targeted auditing on at least a monthly basis. Information taken from the dashboard along with grievance and complaint call information will be used to develop monitoring and auditing work plans. Monitoring and auditing work plans are used to detect potential areas of risk and/or non-compliant activity. The monitoring and auditing work plans are subject to daily updates and additions, and are therefore, working documents. The ***Compliance Officer***, or his/her ***designee,*** in collaboration with the ***AOC*** and ***Compliance Committee***, develops the monitoring and auditing work plans to address the risks associated with each of ***CalOptima's programs***.

The ***Compliance Officer,*** or his/her ***designee,*** will coordinate with CalOptima's Audit & Oversight Department in connection with appropriate auditing and ***monitoring activities***. ***Audits*** for each operational area will be conducted throughout the year consistent with the monitoring and auditing work plans. The Compliance Officer, or his/her ***designee,*** will coordinate the ***audits*** with internal ***audit*** staff, and, in some cases, with the assistance from an outside vendor. ***Audit*** methodologies shall be consistent with regulatory and NCQA requirements and standards. All ***audits*** will include review of applicable documents and evaluation of actual processes to ensure compliance with all applicable regulations and contractual obligations. Once the ***audit*** review is completed, the ***audit*** team will communicate the results to the ***Compliance Officer*** and propose follow up corrective action(s), if necessary. The ***Compliance Officer,*** or his/her ***designee,*** will provide reports to the CEO and the ***Compliance Committee*** concerning the results of the ***audits***. The ***AOC*** reports to the ***Compliance Officer*** and the ***Compliance Committee*** on ***audits*** that involve ***FDRs*** as discussed below. If ***FWA*** issues are identified during an ***audit***, the matter will be further investigated and resolved in a timely manner. In addition, an ***audit*** of the ***Compliance Program*** and its effectiveness should occur at least annually, and the results shall be reported to the ***CalOptima Board***.

c. Oversight of Delegated Activities

To ensure the terms and conditions of statutory and contractual obligations to ***CMS***, ***DHCS***, and other governmental and regulatory entities are adhered to, CalOptima implements a comprehensive oversight monitoring and auditing process of ***FDRs*** who perform delegated activities. The processes that CalOptima implements to oversee, monitor, and ***audit FDRs*** are incorporated into CalOptima's written ***policies and procedures***, including processes involving pre-contractual evaluations and ***audits*** of ***First Tier Entities***. CalOptima may implement ***Corrective Action Plans***, ***sanctions***, and/or revoke its ***delegation*** of duties (in a manner permitted under the contract) if CalOptima determines that an ***FDR*** is unable or unwilling to carry out its responsibilities consistent with statutory and contractual obligations.

The ***Compliance Officer***, or his/her ***designee***, determines the process for monitoring delegated ***FDRs*** and develops the annual monitoring and ***audit*** calendar in order to validate compliance with contractual standards and regulatory requirements. The ***AOC*** is responsible for overseeing all of the delegated activities and will review the readiness assessment, ensure the annual review of ***FDRs*** for delegated functions are completed, conduct formal on-going evaluation of ***FDR*** performance and compliance, ensure ***Downstream*** and ***Related Entities*** are monitored, and impose ***Corrective Action Plans*** and/or ***sanctions*** if the ***FDR***'s performance fails to meet statutory and contractual standards and requirements. The ***AOC*** may recommend termination of ***delegation*** to the ***Compliance Committee*** for unresolved matters.

d. Monitoring and Audit Review Process for FDRs

1. *Initial Evaluation*

Prior to executing a contract or ***delegation*** agreement with a potential ***FDR***, a risk assessment is performed to determine the type of initial evaluation that will be performed. If it is deemed necessary, an initial evaluation, referred to as a Readiness Assessment as detailed in CalOptima's ***policies and procedures***, is completed to determine the ability of the potential ***FDR*** to assume responsibility for delegated activities and to maintain CalOptima standards, applicable state, ***CMS***, and regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, review of the entity's operational capacity and resources to perform the delegated functions, evaluation of the entity's ability to meet contractual and regulatory requirements, verification that the entity is not precluded on the Preclusion List, excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the ***DHCS*** Medi-Cal Provider Manual from participating in health programs, and/or an initial onsite evaluation. Results of the initial evaluation are presented to the ***AOC*** and subsequently the ***Compliance Committee*** for review and/or approval.

2. *Contracting with FDRs*

Once an entity has been approved, the ***delegation*** agreement specifies the activities CalOptima delegates to the ***FDRs***, each party's respective roles and responsibilities, reporting requirements and frequency, submission of data requirements, the process for performance evaluations and ***audits***, and remedies, including disciplinary actions, available to CalOptima. Prior to any ***sub-delegation*** to any ***Downstream*** or ***Related Entity***, a ***First Tier Entity*** must obtain approval from CalOptima. CalOptima determines who will directly monitor the ***Downstream*** or ***Related Entity***'s compliance with requirements.

FDRs shall be required to institute a training program consistent with CalOptima's requirements intended to communicate CalOptima's compliance requirements as well as compliance characteristics related to the ***FDR*** and their contractually delegated area(s). Furthermore, ***FDRs*** will be required to complete, sign, and return attestation forms confirming the ***FDR***'s compliance with new hire and annual training and education requirements, which includes courses on general compliance and ***FWA*** as well as exclusion and preclusion screening and ***FWA*** reporting obligations.

3. *Annual Risk Assessment*

The ***Compliance Officer***, or his/her ***designee***, will ensure that an annual comprehensive risk assessment is conducted in accordance with CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate) to determine the ***FDR***'s vulnerabilities and high-risk areas. High risk ***FDRs*** are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima requirements. Any previously identified issues, which include any corrective actions, service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any ***FDR*** deemed high risk, or vulnerable, is presented to the ***AOC*** for suggested follow-up ***audit***. ***FDRs*** determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from

FDRs, will be managed by the ***Compliance Officer***, or his/her ***designee***, and presented to the ***AOC*** and subsequently to the ***Compliance Committee*** for review and approval.

4. *FDR Performance Reviews and Audits*

CalOptima conducts a periodic comprehensive performance review of the ***FDR***'s ability to provide delegated services in accordance with contractual standards and applicable state, ***CMS***, and accreditation requirements, as further detailed in CalOptima's ***policies and procedures***. CalOptima may conduct ***audits*** of ***FDRs*** at any time. Such ***audits*** may include an evaluation of the ***FDR***'s training and education program and materials covering general compliance and ***FWA***, as well as compliance with applicable laws, regulations, and contractual obligations governing delegated activities. High-risk ***FDRs***, as determined by the annual risk assessment and/or continued non-compliance, will obtain priority status on the annual ***audit*** calendar; however, CalOptima does not limit its auditing schedule to only high-risk ***FDRs***.

If CalOptima has reason to believe the ***FDR***'s ability to perform a delegated function is compromised, an additional focused ***audit*** may be performed. The ***Compliance Officer,*** or his/her ***designee,*** may also recommend focused ***audits*** upon evaluation of non-compliant trends or reported incidents. The results of these ***audits*** will be reported to the ***AOC*** and then to the ***Compliance Committee***.

A focused ***audit*** may be initiated for any of the following activities, or any other reason at the discretion of CalOptima:

- Failure to comply with regulatory requirements and/or CalOptima's service level performance indicators;
- Failure to comply with a ***Corrective Action Plan***;
- Reported or alleged ***fraud***, ***waste***, and/or ***abuse***;
- Significant policy variations that deviate from the CalOptima or state, ***CMS***, or accreditation requirements;
- Bankruptcy, or impending bankruptcy, which may impact services to ***members*** (either suspected or reported);
- Sale, merger, or acquisition involving the ***FDR***;
- Significant changes in the management of the ***FDR***; and/or
- Changes in resources which impact CalOptima's and/or the ***FDR***'s operations.

5. *Corrective Actions and Additional Monitoring and Auditing*

The ***Compliance Officer,*** or his/her ***designee,*** shall submit regular reports of all monitoring, ***audit***, and corrective action activities to the ***Compliance Committee***. In instances where non-compliance is identified, a ***Corrective Action Plan*** shall be developed by the ***FDR*** and reviewed and approved by the ***Compliance Officer***, or his/her ***designee***. Every ***Corrective Action Plan*** is presented to the ***AOC*** for review. Supplemental and focused ***audits*** of ***FDRs***, as well as additional reporting, may be required until compliance is achieved.

At any time, CalOptima may implement ***sanctions*** or require remediation by an ***FDR*** for failure to fulfill contractual obligations including development and implementation of a ***Corrective Action Plan***. Failure to cooperate with CalOptima in any manner may result in termination of the ***delegation*** agreement, in a manner authorized under the terms of the agreement.

e. Evaluation of Audit Activities

An external review of CalOptima's auditing process is conducted through identified process measures. These measures support organizational, accreditation, and regulatory requirements and are reported on a yearly basis. CalOptima uses an independent, external consultant firm to periodically review the auditing processes, including ***policies and procedures***, ***audit*** tools, and ***audit*** findings, to ensure all regulatory requirements are being audited in accordance with industry standards/practices and are in compliance with federal and state regulations.

The current measures reviewed include:

- The central database of all pending, active, and terminated ***FDRs*** to monitor and track functions, performance, and ***audit*** schedules;
- Implementation of an escalation process for compliance/performance issues;
- Implementation of a process for validation of ***audit*** tools;
- Implementation of a process for noticing ***FDRs*** and functional areas of ***Corrective Action Plans***;
- Tracking and trending internal compliance with oversight standards, performance, and outcomes;
- Implementation of an annual training program for internal staff regarding ***delegation*** standards, auditing, and monitoring ***FDR*** performance; and/or
- Implementation of a process for dissemination of regulatory changes to include Medi-Cal and Medicare lines of business.

The following key performance metrics will be evaluated and reported periodically:

- Evaluations of ***FDR*** performance and reporting of delegated functions in accordance with the terms of the agreement;
- Number of annual oversight ***audits*** completed within twelve (12) months; and
- ***Corrective Action Plans*** (***CAPs***) completed within the established timeframe.

f. Regular Exclusion and Preclusion Screening

As detailed in CalOptima's ***policies and procedures***, CalOptima performs ***Participation Status*** Reviews by reviewing the OIG –LEIE, the GSA–SAM, the ***DHCS*** Medi-Cal Suspended & Ineligible Provider Lists, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure ***Board members***, ***employees***, and/or ***FDRs***

are not excluded, or do not become excluded or precluded from participating in ***Federal and/or State health care programs***. ***Board members***, ***employees***, and ***FDRs*** are required to disclose their ***participation status*** as part of their initial appointment, employment, commencement of the contract and registration/application processes and when ***Board members***, ***employees***, and ***FDRs*** receive notice of a suspension, preclusion, exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima also requires that its ***First Tier Entities*** comply with ***Participation Status*** Review requirements with respect to their relationships with ***Downstream Entities***, including without limitation, the delegated credentialing and re-credentialing processes.

The ***Compliance Officer,*** or his/her ***designee,*** will review reports from ***employees*** responsible for conducting the ***Participation Status*** Reviews to ensure ***employees*** record and maintain the results of the reviews and notices/disclosures. Employees shall immediately notify the ***Compliance Officer*** of affirmative findings of a person, or entity's, failure to meet the ***Participation Status*** Review requirements. If CalOptima learns that any prospective, or current, ***Board member***, ***employee***, or ***FDR*** has been proposed for exclusion, excluded, or precluded, CalOptima will promptly remove him/her/the ***FDR*** from ***CalOptima's programs*** consistent with applicable policies and/or contract terms.

Payment may not be made for items or services furnished, or prescribed, by an excluded person, or entity. Payments made by CalOptima to excluded persons, or entities, after the effective date of their suspension, exclusion, debarment, or felony conviction, and/or for items or services furnished at the medical direction, or on the prescription of a physician who is suspended, excluded, or otherwise ineligible to participate, are subject to repayment/recoupment. Such requirements also apply to providers on the CMS Preclusion List, consistent with regulatory guidance, applicable policies and/or contract terms. The ***Compliance Officer,*** or his/her ***designee,*** will review potential organizational obligations related to the reporting of identified excluded, precluded, or suspended, individuals, or entities, and/or refund obligations and consult with legal counsel, as necessary and appropriate, to resolve such matters.

VII.RESPONSE AND REMEDIATION

a. Response to Notice of Violation or Suspected Violation

Upon receipt of a report or notice of violation or suspected violation of CalOptima's ***Compliance Program*** and/or ***FWA*** issues, the ***Compliance Officer,*** or his/her ***designee,*** shall, upon promptly verifying the facts related to the violation or likely violation, notify the ***Compliance Committee***, as appropriate. The ***Compliance Committee*** (in consultation with legal counsel, as appropriate) shall determine a response as soon as practicable, which shall include, but not be limited to:

- Recommending investigation of all aspects of the suspected violation or questionable conduct;
- Approving disciplinary actions, ***sanctions***, termination of any agreement and/or any other corrective action (including repayment of ***overpayments***) consistent with applicable ***policies and procedures***, subject to consultation with legal counsel and/or notifying the ***Governing Body***, as appropriate;
- Implementing education and training programs for ***Board members***, ***employees***, and/or ***FDRs***, where applicable, to correct the violation and prevent recurrence;
- Amending, if necessary, CalOptima's ***Compliance Plan***, ***Code of Conduct***, and/or relevant ***policies and procedures*** in an effort to avoid any future recurrence of a violation; and/or
- Ensuring that compliance reports are kept confidential, where permitted by law, and if appropriate, protected under applicable privileges, including, but not limited to, the attorney/client privilege and ensuring that all files regarding compliance matters are appropriately secured.

It is the responsibility of the ***Compliance Officer*** and the ***Compliance Committee*** to review and implement any appropriate corrective and/or disciplinary action in consultation with the Human Resources Department, as applicable, consistent with applicable ***policies and procedures*** after considering such recommendations. The ***Compliance Officer***, or his/her ***designee***, shall monitor and review corrective actions after their implementation to ensure that they are effective.

b. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima shall report violations of Medi-Cal Program requirements to ***DHCS*** Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

c. Response to Fraud Alerts

CMS issues alerts to Part D sponsors concerning ***fraud*** schemes identified by law enforcement officials. Typically, these alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers participating in illegal remuneration schemes. CalOptima may take action (including denying or reversing claims) in instances where CalOptima's own analysis of its claims

activity indicates that ***fraud*** may be occurring. CalOptima's decision to deny, or reverse, claims shall be made on a claim-specific basis.

When a ***fraud*** alert is received, CalOptima shall review its ***delegation*** agreements with the identified parties, and shall consider terminating the contract(s) with the identified parties if indictments have been issued against the particular parties and the terms of the ***delegation*** agreement(s) authorizes contract termination.

CalOptima is also obligated to review its past paid claims from entities identified in a ***fraud*** alert. With the issuance of a ***fraud*** alert, ***CMS*** places CalOptima on notice (see Title 42, Code of Federal Regulations, §423.505(k)(3)) that claims involving the identified party needs to be reviewed. To meet the "best knowledge, information, and belief" standard of certification, CalOptima shall make its best efforts to identify claims that may be, or may have been, part of an alleged ***fraud*** scheme and remove them from the sets of prescription drug event data submissions.

d. Identifying and Monitoring Providers with a History of Complaints

CalOptima shall maintain files for a period of ten (10) years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes member complaints, ***DHCS*** Audits and Investigations referrals, MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of ***Federal and/or State health care programs*** requirements. CalOptima shall also maintain files that contain documented warnings (e.g., ***fraud*** alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. CalOptima shall comply with requests by law enforcement, ***DHCS***, ***CMS***, and ***CMS***' ***designee***, regarding monitoring of ***FDRs*** within CalOptima's network that ***DHCS***, or ***CMS***, has identified as potentially abusive, or fraudulent.

e. Identifying and Responding to Overpayments

CalOptima shall sustain an effective system for the review of suspect claims to detect and prevent ***FWA*** within a CalOptima program. All suspect claims shall be thoroughly investigated to determine whether such claims are the direct result of ***FWA*** activity. CalOptima shall assess all ***FDRs*** for potential ***overpayments*** when reviewing and undertaking corrective actions. Upon completion of the suspect claim(s) investigation(s), CalOptima shall recoup and/or return ***overpayments*** consistent with applicable laws and regulatory guidance. Should revisions to reported data be required, CalOptima and/or FDR shall update appropriate data sources and reports, via documenting and/or resubmission, as appropriate. The resolution(s) for suspect claim(s) investigation(s) may include, but is not limited to: (i) recoupment through established procedures, (ii) provider education about billing protocols, and (iii) reporting of ***overpayment*** determinations to regulatory agencies, as required by law.

C. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of ***FWA*** are components of CalOptima's ***Compliance Program***. ***FWA*** activities are implemented and overseen by CalOptima's ***Compliance Officer,*** or his/her ***designee,*** in conjunction with other compliance activities, and investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima's Office of Compliance, responsible for ***FWA*** investigations. The ***Compliance Officer,*** or his/her ***designee,*** reports ***FWA*** activities to the CalOptima ***Compliance Committee***, CEO, the ***CalOptima Board***, and regulatory agencies.

CalOptima utilizes various resources to detect, prevent, and remediate ***FWA***. In addition, CalOptima promptly investigates suspected ***FWA*** issues and implements disciplinary, or corrective, action to avoid recurrence of ***FWA*** issues. The objective of the ***FWA*** program is to ensure that the scope of benefits covered by the ***CalOptima programs*** is appropriately delivered to ***members*** and resources are effectively utilized in accordance with federal and state guidelines. CalOptima incorporates a system of internal assessments which are organized to identify ***FWA*** and promptly respond appropriately to such incidents of ***FWA***.

I.TRAINING

As detailed above, ***FWA*** training is provided to all ***Board members*** and ***employees*** as part of the overall compliance training courses in order to help detect, prevent, and remediate ***FWA***. ***FDRs*** are also required to complete ***FWA*** training, as described above. CalOptima's ***FWA*** training provides guidance to ***Board members***, ***employees***, and ***FDRs*** on how to identify activities and behaviors that would constitute ***FWA*** and how to report suspected, or actual, ***FWA*** activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual ***FWA***;
- Examples of the most common types of member ***FWA*** (see Appendix B, attached hereto and incorporated herein) and ***FDR FWA*** (see Appendix C, attached hereto and incorporated herein) as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify ***FWA*** in ***CalOptima programs*** (*e.g.,* suspicious activities suggesting CalOptima members, or their family ***members***, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, or enrolling, individuals in the ***CalOptima programs***, etc.);
- Information on how to identify potential prescription drug ***FWA*** (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, high-volume prescriptions of a particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);

- How to report potential ***FWA*** using CalOptima's reporting options, including CalOptima's Compliance and Ethics Hotline, and for ***FDRs***, reporting obligations;
- CalOptima's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the ***False Claims Act*** and CalOptima's requirement to train ***employees*** and ***FDR***s on the ***False Claims Act*** and other applicable ***FWA*** laws.

CalOptima shall provide ***Board members***, ***employees***, ***FDRs***, and ***members*** with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

II.DETECTION OF FWA

a. Data Sources

In partnership with the Regulatory Affairs & Compliance Department, CalOptima's SIU utilizes different sources and analyzes various data information in an effort to detect patterns of ***FWA***. Potential fraudulent cases will not only come from claims data but can also originate from many sources internally and externally. ***Members***, ***FDRs***, ***employees***, law enforcement and regulatory agencies, and others are able to contact CalOptima by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima, such as enrollment, finance, or data submission.

Sources used to detect ***FWA*** include, but are not limited to:

- CalOptima's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record ***audits***;
- ***Member*** and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and ***monitoring activities***;
- Monitoring external health care ***FWA*** cases and determining if CalOptima's ***FWA*** Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and ***audits***.

b. Data Analytics

CalOptima uses technology and data analysis to reduce ***FWA*** externally. Using a combination of industry standard edits and CalOptima-specific edits, CalOptima identifies claims for which procedures have been unbundled, or upcoded. CalOptima also identifies suspect ***FDRs*** based on billing patterns.

CalOptima also uses the services of an external Medicare Secondary Payer (MSP) vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, OneCare Connect, and/or PACE programs, by ensuring that Federal and State funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data is analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed in accordance with applicable state or federal law if they meet certain criterion that warrants additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (for example narcotics), provider patterns, and challenges previously reported pertaining to certain pharmacies. CalOptima along with the PBM will conduct data mining activities in order to identify potential issues of ***FWA***.

The following trends will be reviewed and flagged for potential ***FWA***, including:

- Over utilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual Coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by ***members*** and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses; and/or

- Peer to peer comparisons within specialties.

Once vulnerabilities are identified, immediate actions are taken in order to mitigate the possible losses, including, but not limited to, claims denial or reversal and/or the reporting of suspected ***FWA***. The data review includes, but is not limited to:

- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM will go through the same risk assessment process. The analysis will be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the beneficiary, or makes arrangements to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a ***member*** is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale, or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides a number of refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No one (1) indicator is evidence of ***FWA***. The presence of several indicators may suggest ***FWA***, but further investigation is needed to determine if a suspicion of ***FWA*** actually exists. The following list below highlights common industry indicators and red flags that are used to determine whether or not to investigate an ***FDR*** or their claim disposition:

- Claims that show any altered information (dates; codes; names).

- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the ***member***/patient's last name.
- Insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the ***FWA*** database and a report is generated and submitted to the ***Compliance Officer***, ***Compliance Committee***, and CEO.

III.INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected ***FWA*** or detects ***FWA*** through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the Fraud Tracking Database (Access database maintained by SIU on an internal drive);
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive, by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from CalOptima's Legal Counsel on specific cases, or issues;
- Quality of care issues are referred to CalOptima's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an ***FDR*** to obtain relevant information;
- SIU, or a ***designee***, interviews the individual who reported the ***FWA***, affected ***members*** and/or ***FDRs***, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of ***FDR*** enrollment applications, history, and ownership, as necessary;
- Review of member enrollment applications and other documents, as necessary;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the Fraud Tracking Database, the investigation is tracked to its ultimate conclusion, and the Fraud Tracking Database shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods, if appropriate;

- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation shall be forwarded to the ***Compliance Officer*** and ***Compliance Committee*** for discussion and approval.

IV.FINDINGS, RESPONSE, AND REMEDIATION

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of ***FWA***, need for contract amendment, education and training requirement, recommendation of focused ***audits***, additional investigation, continued monitoring, new policy implementation, and/or criminal or civil action. When the root cause of the potential ***FWA*** issue has been identified, the SIU will track and trend the ***FWA*** allegation and investigation, including, but not limited to, the data analysis performed, which shall be reported to the ***Compliance Committee*** on a quarterly basis. Investigation findings can be used to determine whether or not disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima's ***policies and procedures***, and/or whether the matter should be reported to applicable state and federal agencies.

In accordance with applicable CalOptima ***policies and procedures***, CalOptima shall take appropriate disciplinary, or corrective, action against ***Board members***, ***employees***, and/or ***FDRs*** related to validated instances of ***FWA***. CalOptima will also assess ***FDRs*** for potential ***overpayments*** when reviewing and undertaking corrective actions. Corrective actions will be monitored by the ***Compliance Committee***, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial ***sanctions***, regulatory reporting, ***Corrective Action Plans***, or termination of the ***delegation*** agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Office of Compliance will initiate review and discussion at the first ***Compliance Committee*** following the date of identification of the suspected ***FWA***, the date of report to ***DHCS***, or the date of ***FWA*** substantiation by ***DHCS*** subsequent to the report. If vulnerability is identified through a single ***FWA*** incident, the correction action may be applied universally.

V.REFERRAL TO ENFORCEMENT AGENCIES

CalOptima's SIU shall coordinate timely referrals of potential ***FWA*** to appropriate regulatory agencies, or their designated program integrity contractors, including the ***CMS*** MEDIC, ***DHCS*** Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. ***FDRs*** shall report ***FWA*** to CalOptima within the time frames required by the applicable contract and in sufficient time for CalOptima to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected ***FWA***, should be reported to ***CMS*** and/or ***DHCS***, as soon as possible after discovery, but no later than ten (10) working days to ***DHCS*** after CalOptima first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to MEDIC after a OneCare, OneCare Connect, or PACE case is reported to CalOptima's SIU.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of ***FWA***;
- Patterns of ***FWA*** threatening the life, or well-being, of CalOptima ***members***; and/or
- Schemes with large financial risk to CalOptima, or its ***members***.

VI.ANNUAL EVALUATION

CalOptima's ***Compliance Committee*** shall periodically review and evaluate the ***FWA*** activities and its effectiveness as part of the overall ***Compliance Program audit*** and ***monitoring activities***. Revisions should be made based on industry changes, trends in ***FWA*** activities (locally and nationally), the OIG Work Plan, the CalOptima ***Compliance Plan***, and other input from applicable sources.

VII.RETENTION OF RECORDS

CalOptima shall maintain reports and summaries of ***FWA*** activities and all proceedings of the various committees in original, electronic, or other media format in accordance with applicable statutory, regulatory, contractual, CalOptima policy, and other requirements. CalOptima shall file copies of member records containing PHI in a secure and confidential manner, regardless of the outcome of a review. CalOptima shall file copies of ***FWA*** investigations in a secure and confidential manner, regardless of the outcome of an investigation.

VIII.CONFIDENTIALITY

CalOptima and its ***FDRs*** shall maintain all information associated with suspected, or actual, ***FWA*** in confidential files, which may only be released in accordance with applicable laws and CalOptima ***policies and procedures***. All participants and attendees of CalOptima's Quality Improvement Committee, ***Compliance Committee***, and respective subcommittees, shall sign a "Confidentiality Agreement" agreeing to hold all committee discussions confidential.

D. COMPLIANCE PROGRAM EVALUATION

In order to ensure the effectiveness of the ***Compliance Program***, CalOptima will conduct a self-assessment no less than annually. The assessment will evaluate the ***Compliance Program*** against the elements of an effective ***Compliance Program*** as recommended by OIG and required by ***CMS*** regulations. The following areas will be reviewed:

- ***Policies and procedures***;
- ***Compliance Officer*** and ***Compliance Committee***;
- Training and education of ***Board members***, ***employees***, and ***FDRs***;
- Effective lines of communication;
- Well publicized disciplinary guidelines;
- Internal monitoring and auditing;
- ***Delegation*** oversight;
- Exclusion and preclusion screening process; and
- Prompt responses to detected offenses.

The ***Compliance Program*** will be evaluated no less than annually by an outside entity. The results of the evaluation will be shared with ***senior management***, the ***Compliance Committee***, and the ***CalOptima Board***. Updates to the ***Compliance Program*** will be based on the results of the evaluation and will be referred to the ***CalOptima Board*** for review and approval.

I.FILING SYSTEMS

The ***Compliance Officer,*** or his/her ***designee,*** shall establish and maintain a filing system (or systems) for all compliance-related documents. The following files shall be established at CalOptima (as applicable):

a. Compliance Plan, Code of Conduct, and Policies and Procedures File

This file shall contain copies of the following (unless originals specified):

- ***Compliance Plan*** and any amendments;
- Any ***Compliance Program policies and procedures*** issued after the initiation of the ***Compliance Program***;
- Reports to, and Resolutions/Minutes of CalOptima's Board approving the Compliance Program, ***Compliance Plan***, ***Code of Conduct*** and/or appointment of the ***Compliance Officer***;
- All non-privileged communications to the ***Compliance Officer*** (original);
- All ***Compliance Committee*** and ***CalOptima Board*** minutes in which compliance issues are discussed; and/or
- Any other written records of the ***AOC***, or other oversight activities (originals if generated by the ***Compliance Officer***).

b. Information and Education File

This file shall contain copies of the following (unless originals specified):

- ***FDR*** training and attestation records (including attendance records, Affirmation Statements, and the outline of topics covered);
- ***Board member*** and ***employee*** training records, attestations, and attendance records are maintained by the Human Resources Department.
- Educational materials provided to ***Board members***, ***employees***, and ***FDRs***;
- Notices, ***fraud*** alerts, and/or federal and state laws and regulations which have been posted on bulletin boards, placed in payroll stuffers, or sent via print or electronic communication (and the dates and locations of such notices); and/or
- All other written records of training activities.

c. Monitoring, Enforcement, and Response File

This file shall contain copies of the following (unless originals specified):

- Records relating to compliance reports including reports to the Compliance and Ethics Hotline

and/or to the ***Compliance Officer*** (originals);

- Records relating to periodic monitoring and auditing of the ***Compliance Program*** (originals);
- Records relating to ***Board member***, ***employee***, and ***FDR Participation Status*** Review or background checks (originals except where ***FDRs*** perform ***Participation Status*** Reviews);
- Records relating to established periodic monitoring mechanisms;
- All documents pertaining to the enforcement of the ***Compliance Program***, including, investigations and disciplinary and/or corrective actions; and/or
- All documents reflecting actions taken after an offense has been detected, and all efforts to deter and prevent future violations.

d. Privileged File

This file shall be protected by, and marked, privileged and confidential and its contents shall be kept in a secure location. Only the ***Compliance Officer***, legal counsel, and the ***Compliance Committee***, where appropriate, shall have access to its contents. All material in this file shall be treated as attorney-client privileged and shall not be disclosed to persons outside the privileged relationship. This file contains the following original documents (except where only a copy is available):

- Records of requests for legal assistance or legal opinion(s) in connection with Compliance and Ethics Hotline telephone calls, correspondence related thereto, and/or problems reported to the ***Compliance Officer***;
- The response from legal counsel regarding any such issues; and/or
- Legal opinions concerning ***FDR delegation*** agreement interpretations and remedies available to CalOptima.

e. Document Retention

All of the documents to be maintained in the filing system described above shall be retained for no less than ten (10) years from end of the fiscal year in which the CalOptima Medi-Cal contract expires, or is terminated (other than privileged documents which shall be retained until the issue raised in the documentation has been resolved, or longer if necessary). Records pertaining to CalOptima's OneCare, OneCare Connect, or PACE programs shall also be retained for ten (10) years from end date of the applicable contract.

CalOptima shall maintain the documentation required by ***HIPAA*** for at least six (6) years from the date of its creation or the date when it last was in effect, whichever, is later. Such documentation includes: (i) ***policies and procedures*** (and changes thereto) designed to comply with the standards, implementation specifications or other designated requirements; (ii) writings, or electronic copies, of communications required by ***HIPAA***; (iii) writings, or electronic copies, of actions, activities, or designations required to be documented under ***HIPAA***; and (iv) documentation to meet its burden of proof related to identification of breaches under Title 45, Code of Federal Regulations, §164.414(b).

Appendix A

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision, and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** 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 CalOptima members. **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board members, employees, and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, employees and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste, & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste, and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste, and abuse. CalOptima is also responsible for ensuring that Board members, employees, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste, and Abuse Plan and policies describe examples of potential fraud, waste, and abuse and discuss employee and contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Principle	Standard
	Political Activities CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment

Principle	Standard
	and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its physician groups, its health networks and third party administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima policies and applicable laws.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.
Public Integrity	**Public Records**

Principle	Standard
CalOptima and its Board members and employees shall comply with laws and regulations governing public agencies.	CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima policies. **Public Funds** CalOptima, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and employees shall comply with applicable law and CalOptima policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima's policies and procedures. **Personnel Files**

Principle	Standard
	Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima, or CalOptima members. **Gifts to CalOptima** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima.

Principle	Standard
	Third-Party Sponsored Events CalOptima's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima policies on this subject. In no event, shall CalOptima participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any contractor or association of contractors.

Principle	Standard
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, and gender expression), sexual orientation, health status, physical or mental disability, or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, physician groups, and health networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of employees, individuals and entities doing business with CalOptima by conducting regular exclusion and preclusion screening reviews in accordance with CalOptima policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima requires that its health networks, physician groups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Principle	Standard
	Licensure CalOptima requires that all employees, contractors, health networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.
Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima's own policies in accordance with CalOptima's reporting policies and its Compliance Plan. Such reports may be made to a supervisor or the Compliance Officer. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for

Principle	Standard
	failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima or exclusion or preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, employees and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable policies.

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Appendix B

TYPES OF MEMBER FWA

MEMBER FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M02	Selling, loaning, or giving a member's identity or documentation of Medi-Cal eligibility to obtain services.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M03	Making an unsubstantiated declaration of eligibility.	Members with multiple areas of service; members who attempt more than one (1) PCP; reports of members who are hiding assets or income.
M04	Using a covered service for purposes other than the purpose for which it was described including use of such covered service.	Selling a covered wheelchair; selling medications; abusing prescription medications.
M05	Failing to report other health coverage.	Payments by OHI.
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive covered services.	Hotline reports; internal reports; reports by health networks.
M07	Other (please specify).	Any source.
M08	Member Pharmacy Utilization	PBM reports; data analytics; claims data; encounter data; FWA software.
M09	Doctor Shopping	PBM reports; data analytics; claims data; encounter data; FWA software.
M10	Altered Prescription	Provider report; DEA report; pharmacy report; PBM reports; data analytics; claims data; encounter data; FWA software.

Appendix C

TYPES OF FDR FWA

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima program.	Provider information not able to be verified during credentialing or contracting process; providers on the excluded or precluded provider list.
P02	Submission of claims for covered services that are substantially and demonstrably in excess of any individual's usual charges for such covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P03	Submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	PBM reports; data analytics; claims data; encounter data; FWA software; verification survey; hotline.
P04	Submission of claims for covered services that are in excess of the quantity that is medically necessary.	PBM reports; data analytics; claims data; encounter data; FWA software.
P05	Submission of claims for covered services that are billed using a code that would result in great payment than the code that reflects the covered services.	PBM reports; data analytics; claims data; encounter data; FWA software.
P06	Submission of claims for covered services that is already included in the capitation rate.	PBM reports; data analytics; claims data; encounter data; FWA software.
P07	Submission of claims for covered services that are submitted for payment to both CalOptima and another third-party payer without full disclosure.	PBM reports; data analytics; claims data; encounter data; FWA software; payment by OHI.
P08	Charging a member in excess of allowable co-payments and deductibles for covered services.	Member report; hotline report; oversight audits.
P09	Billing a member for covered services without obtaining written consent to bill for such services.	Member report; hotline report; oversight audits.
P10	Failure to disclose conflict of interest.	Hotline; credentialing or contracting process.
P11	Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a member.	Hotline report; oversight report.
P12	Failure to register billing intermediary with the Department of Health Care Services.	Oversight audit; report by regulatory body; hotline.

FDR FRAUD, WASTE OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P13	False certification of medical necessity.	Medical record review; claims data; encounter data; FWA software.
P14	Attributing a diagnosis code to a member that does not reflect the member's medical condition for the purpose of obtaining higher reimbursement.	Medical record review; claims data; encounter data; FWA software.
P15	False or inaccurate minimum standards or credentialing information.	Hotline; credentialing or contracting process.
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations.	Medical record review; claims data; encounter data; FWA software.
P17	Other (please specify).	Any source.
P18	Provider Pharmacy Utilization.	PBM reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; hotline report; oversight audits.
P20	Durable Medical Equipment- covered services that are not actually provided to member.	Member report; hotline report; oversight audits; verification survey.

Appendix D

TYPES OF EMPLOYEE FWA

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a member's identity or documentation of Medi-Cal eligibility to obtain services.	Employees obtaining services on a member's account. Hotline report. Data analytics. Referrals to SIU.
E02	Use of a member's identity or documentation of Medi-Cal eligibility to obtain a gain.	Employees obtaining unjust enrichment, funds, or other gain by selling member's account information. Hotline report.
E03	Employee assistance to providers with the submission of claims for covered services that are not actually provided to the member for which the claim is submitted.	Employees obtaining unjust enrichment, funds, or other gain from provider by using member's account information to assist in the submission of false claims. Hotline report. Referrals to SIU.
E04	Employee deceptively accessing company confidential information for purpose of a gain.	Employees obtaining unjust enrichment, funds, or other gain from another by deceptive and unauthorized accessing of information. Hotline Service. Data Analytics. Referrals to SIU.

Appendix E

AFFIRMATION STATEMENTS

CalOptima
AFFIRMATION STATEMENT-SUPERVISORS

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

I understand that it is my responsibility to respond to questions from employees under my direct supervision regarding the Compliance Plan, Code of Conduct, or applicable Policies and Procedures. If I am unable to respond to questions from employees under my direct supervision, I will refer them to the Compliance Officer. In addition, I understand that if an employee under my direct supervision reports a violation or suspected violation of CalOptima's Compliance Program to me, I will escalate and report the issue to the Compliance Officer.

By signature below, I also certify that I have completed the Compliance Training as indicated:

I attended the initial Compliance Training Session on _____.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-EMPLOYEES

I have received and read a copy of the Compliance Plan, Code of Conduct, and relevant Policies and Procedures specific to my job duties and responsibilities as part of my compliance training, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the Compliance Training Session on _____:

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

CalOptima
AFFIRMATION STATEMENT-FDRs

I have received and read a copy of the Compliance Plan, Code of Conduct, and applicable Policies and Procedures relevant to the delegated activities, and I understand, acknowledge, and agree to abide by its contents and requirements.

I will disseminate the Compliance Plan, Code of Conduct, and applicable Policies and Procedures to those employees and agents who will furnish items or services to CalOptima under the Contractor Agreement.

_____
Print Name

_____
Signature

_____
Title

_____
Company

_____
Date

SIGN, DATE AND RETURN TO CalOptima SUPERVISOR

CalOptima
AFFIRMATION STATEMENT-BOARD MEMBERS

I have received and read a copy of the Compliance Plan, the Code of Conduct, and applicable Policies and Procedures, and I understand, acknowledge, and agree to abide by its contents and requirements.

By signature below, I also certify that I have completed the initial or regular training as indicated:

I attended the initial Compliance Training Session on _____.
I attended the annual Compliance Training Session on _____.

_____
Print Name

_____
Signature

_____
Date

RETURN TO THE COMPLIANCE OFFICER

E. GLOSSARY

Abuse ("Abuse") means actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit ("Audit") means 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 (1) of several acknowledged certifications.

Audit & Oversight Committee ("AOC") means a subcommittee of the Compliance Committee chaired by the Director 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.

Board Members ("Board Members") means the members of the CalOptima Board of Directors.

CalOptima ("CalOptima") means the Orange County Health Authority, d.b.a. CalOptima, a County Organized Health System ("COHS") created under California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

CalOptima Board of Directors ("CalOptima Board") means the Board of Directors of CalOptima, which serves as the Governing Body of CalOptima, appointed by the Orange County Board of Supervisors in accordance with the Codified Ordinances of the County of Orange.

CalOptima Members ("CalOptima members" or "members") means a beneficiary who is enrolled in a CalOptima program.

CalOptima Programs ("CalOptima Programs") means the Medi-Cal program administered by CalOptima under contract with DHCS, the Medicare Advantage Program ("OneCare") administered by CalOptima under contract with CMS, the Program of All Inclusive Services for the Elderly ("PACE") program administered by CalOptima under contract with DHCS and CMS, the Multipurpose Senior Services Program ("MSSP") administered by CalOptima under contract with the California Department of Aging, and the OneCare Connect program administered by CalOptima under contract with DHCS and CMS, as well as any other program now or in the future administered by CalOptima.

Centers for Medicare & Medicaid Services ("CMS") means the federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare

program and works in partnership with state governments to administer Medicaid programs.

Code of Conduct ("Code of Conduct") means the statement setting forth the principles and standards governing CalOptima's activities to which Board Members, employees, FDRs, and agents of CalOptima are expected to adhere.

Compliance Committee ("Compliance Committee") means that committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.

Compliance Plan ("Compliance Plan") means this plan and all attachments, exhibits, modifications, supplements, or amendments thereto.

Compliance Program ("Compliance Program" or "Program") means the program (including, without limitation, this Compliance Plan, Code of Conduct and policies and procedures) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board Members, employees and FDRs comply with applicable law and ethical standards.

Conflict of Interest Code ("Conflict of Interest Code") means CalOptima's Conflict of Interest Code approved and adopted on December 6, 1994, as amended and updated from time to time.

Corrective Action Plan ("CAP") means a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

Delegation ("Delegated") means a legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements, and obligations pertaining to the delegated functions.

Department of Health and Human Services-Office of Inspector General ("OIG") means the Office of Inspector General of the United States Department of Health and Human Services.

Department of Health Care Services ("DHCS") means the California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Department of Managed Health Care ("DMHC") means the California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code Sections 1340 *et seq*.

Designated Employee ("Designated Employee") means the persons holding positions listed in the

Appendix to the CalOptima Conflict of Interest Code.

Designee ("Designee") is 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 ("Downstream Entity") means 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 or Employees ("Employee" or "Employees") means any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Executive Director of Compliance ("Executive Director of Compliance" or "Compliance Officer") means that person designated as the Compliance Officer for CalOptima charged with the responsibility of implementing and overseeing the Compliance Program and the Compliance Plan and Fraud, Waste, and Abuse Plan.

False Claims Act ("FCA") means the False Claims Act pursuant to 31 United States Code [U.S.C.] Sections 3729-3733, which protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government. The "knowing" standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. Civil penalties for violating the FCA may include fines and up to three (3) times the amount of damages sustained by the Government as a result of the false claims. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both. (18 U.S.C. Section 287.)

FDR ("FDR") means First Tier, Downstream or Related Entity, as separately defined herein.

Federal and/or State Health Care Programs ("Federal and/or State health care programs") means "any plan or program providing health care benefits, directly through insurance or otherwise, that is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), including Medicare, or any State health care program" as defined in 42 U.S.C. § 1320a-7b (f) including the California Medicaid program, Medi-Cal.

First Tier Entity ("First Tier Entity") means 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.

Fraud ("Fraud") means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)

Governing Body ("Governing Body") means the Board of Directors of CalOptima.

Health Network or Health Networks ("Health Network" or "Health Networks") means the contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").

Health Insurance Portability and Accountability Act ("HIPAA") means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Monitoring Activities ("Monitoring") means 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.

National Committee for Quality Assurance Standards for Accreditation of MCOs ("NCQA Standards") means the written standards for accreditation of managed care organizations published by the National Committee for Quality Assurance.

Overpayment ("Overpayment") means a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Participating providers and suppliers ("participating providers and suppliers") include all health care providers and suppliers (e.g., physicians, mid-level practitioners, hospitals, long term care facilities, pharmacies, etc.) that receive reimbursement from CalOptima or its health networks for items or services furnished to members. Participating providers and suppliers for purposes of this Compliance Plan may or may not be contracted with CalOptima and/or the health networks.

Participation Status ("Participation Status") means whether a person or entity is currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State health care programs as provided in CalOptima policies and procedures.

Participation Status Review ("Participation Status Review") means the process by which CalOptima reviews its Board members, employees, FDRs, and CalOptima Direct providers to determine whether they are currently suspended, excluded, precluded or otherwise ineligible to participate in Federal and/or State health care programs.

Policies and Procedures ("Policies and Procedures") means CalOptima's written policies and procedures regarding the operation of CalOptima's Compliance Program, including applicable Human Resources policies, outlining CalOptima's requirements and standards in compliance with applicable law.

Related Entity ("Related Entity") means 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 ("Sanction") means an action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or

its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.

Senior Management ("Senior Management") means any employee whose position title is Chief Officer, Executive Director, or Director of one (1) or more departments.

Sub-delegation ("Sub-delegation") means the process by which a first tier entity expressly grants, by formal agreement, to a downstream entity the authority to carry out one or more functions that would otherwise be required to be performed by the first tier entity in order to meet its obligations under the delegation agreement.

Supervisor ("Supervisor" or "Manager") means an employee in a position representing CalOptima who has one (1) or more employees reporting directly to him or her. With respect to FDRs, the term "Supervisor" shall mean the CalOptima employee that is the designated liaison for that contractor.

Third Party Administrator ("TPA") means a contractor that furnishes designated claims processing and other administrative services to CalOptima.

Waste ("Waste") means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

FIRST TIER, DOWNSTREAM, AND RELATED ENTITY (FDR) COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email: Compliance@caloptima.org , or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days (for existing FDRs) or sixty (60) calendar days (for new FDRs) of this notice.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
- ☐ OneCare (HMO SNP)
- ☐ Medi-Cal
- ☐ PACE

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. Provide effective Fraud, Waste and Abuse Training and compliance training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment, or contracting. The Organization and its downstream entities currently use (Select all that apply):

   ☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training modules. (The Organization shall maintain records per CMS retention requirement).

   ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training modules. Organizations with internal training programs are asked to submit a copy of their training materials to be reviewed by CalOptima's Office of Compliance to ensure they meet CMS' requirements. (The Organization shall maintain records per CMS retention requirement).

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non- compliant with program requirements or implicated in past misconduct.

III. Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42, CFR, §422.503(b)(4)(vi)(A) and 42, CFR, §423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire, or contracting, as applicable, and at least annually thereafter.

IV. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the Suspended and Ineligible Provider List (S & I Medi-Cal), Health and Human Services (HHS), Office of Inspector General (OIG) List of Excluded Individuals & Entities list, System for Award Management (SAM)/General Services Administration (GSA) Debarment list (hereafter, "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima.

VII. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. Retain documented evidence of compliance with the above, including training material and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request for auditing purposes.

Note: CalOptima's policies and procedures, CMS training module instructions for Fraud, Waste, and Abuse, General Compliance, General HIPAA, as well as CalOptima's Code of Conduct can be accessed at CalOptima's vendor page: https://www.caloptima.org/en/Vendors.aspx.

Vendors Home -- > FDR Compliance --> Scroll down to Training

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

Signature: _____ Date: _____

Printed Name: _____ Organization: _____

Email: _____

Policy #: HH.2027Δ
Title: **Annual Risk Assessment (Delegate)**
Department: Office of Compliance
Section: Audit ~~&and~~ Oversight

CEO Approval: Michael Schrader _____

Effective Date: 05/01/14
Last Review Date: ~~12/07/17~~12/06/18
Last Revised Date: ~~12/07/17~~12/06/18

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy describes the Annual Risk Assessment process conducted by CalOptima's Audit & Oversight Department to identify delegated First Tier Entities' (~~FTE)~~ FTEs) specific functional areas vulnerable to potential compliance risk. Such areas are documented in CalOptima's risk assessment, which will influence the development of CalOptima's delegated FTE's audit and monitoring work plan.

II. POLICY

A. CalOptima maintains ultimate responsibility for adhering to and otherwise fully complying with its contract with the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS). CalOptima is required to establish and implement an effective system of routine monitoring and identification of compliance risks.

~~A.~~B. At least annually, the Audit & Oversight Department is responsible for completing a ~~Program~~ Annual Risk Assessment to develop its delegated FTE audit and monitoring work plan that ensures CalOptima's regulatory obligations are met. In assessing risk, the Audit & Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;
2. CalOptima's policies and procedures;
3. Business impact on Member care; and
4. Past compliance issues.

C. CalOptima shall, through contract or appropriate written arrangements, require the FTEs to conduct risk assessments, at least annually, and ongoing monitoring and audit of the Downstream Entities with which they contract to ensure compliance. CalOptima shall retain the right to conduct its own risk assessments and ongoing monitoring and audit of the Downstream Entities to ensure compliance.

~~B.~~D. The Audit & Oversight Department shall stay current with all regulatory communication and guidance from the Regulatory Agencies.

~~C.~~E. The Audit & Oversight Department shall present ~~annual risk assessment~~Annual Risk Assessment results and the proposed FTE audit and monitoring work plan to both the Audit & Oversight Committee (AOC) and the Compliance Committee for review and approval by the end of the calendar year to be effective for the following year.

III. PROCEDURE

A. The Audit & Oversight Department shall undertake a discovery process of the FTEs, consisting of a document review to determine how regulatory, statutory, contractual, and CalOptima policy requirements are implemented; the operational effectiveness, and how the practices and the documentation support compliance. The analysis component of the Annual R~~r~~isk A~~a~~ssessment is based on the evaluation of the FTEs' performance during the previous calendar year, including but not limited to monthly monitoring results, annual audit results and focused reviews when applicable.

1. In the event that the ~~First Tier Entity~~FTE is a new delegate, the Audit & Oversight Department shall audit the First Tier Entity to collect baseline data in accordance with CalOptima Policy GG.~~1619A~~1619: Delegation Oversight.

B. The Audit & Oversight Department shall consider the following information as it applies to FTEs, as part of the Annual R~~r~~isk A~~a~~ssessment process:

1. A particular area identified by a Regulatory Agency as problematic through enforcement actions that may impact CalOptima, including but not limited to, National Committee ~~on~~for Quality Assurance (NCQA) status~~.~~;

2. ~~CalOptima~~Regulatory audit findings;

3. ~~Notices~~CalOptima monitoring and audit findings;

4. Regulatory notices of non-compliance;

~~3.~~5. A completed questionnaire by the following CalOptima departments: (i) Regulatory Affairs and Compliance, (ii) Quality Improvement, (iii) Grievance and Appeals Resolution Services, (iv) Privacy, (v) Fraud, Waste & Abuse, and (vi) the business owner to provide knowledge of issues or trends being identified throughout CalOptima.

~~4.~~6. Accuracy of delegate encounter data, submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g., MLR, Hierarchical Condition Category (HCC) risk scores); ~~and~~

~~5.~~7. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliance area; and

8. Whether the FTEs are applying appropriate compliance program requirements to the Downstream Entities with which they contract, conducting risk assessments, at least annually, and performing ongoing monitoring and auditing of such Downstream Entities to ensure compliance.

C. The Audit & Oversight Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment audits evaluating file reviews, data collected from ongoing monitoring results, annual audit results, and number of CAPs issued during the review period.

1. The Audit & Oversight Department shall compile the data and rank the risks based on the greatest impact on delegated operations and quality health care delivery to CalOptima Members.

D. The Audit & Oversight Department shall present the FTE risk assessment results and proposed ~~Audit~~audit and ~~Oversight~~monitoring work plan to the ~~Audit & Oversight Committee (~~AOC~~)~~ and subsequently to the Compliance Committee for approval.

E. The Audit & Oversight Department shall re-evaluate the work plan based on internal changes for approval (e.g., staffing and organizational structure changes, audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, Regulatory Agency audit results, etc.).

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

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 Contract for Health Care Services
E. CalOptima Policy GG.~~1619A~~1619: Delegation Oversight
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. Health Network Service Agreement
H. Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines
I. Prescription Drug Benefit Manual Chapter 9 - Compliance Program Guidelines
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2
K. Welfare and Institutions Code. §14043.1(a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	09/01/2015	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Effective	09/01/2015	HH.2027	Annual Risk Assessment	Medi-Cal
Revised	12/01/2016	HH.2027	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.9117	Annual Risk Assessment	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2027Δ	Annual Risk Assessment (Delegate)	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Annual Risk Assessment Tool	A tool utilized to stratify (high, medium, low) audit results and corrective actions issued to identify specific CalOptima functional areas vulnerable to potential Compliance risk.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	That committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Executive Director of Human Resources.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox Keene Health Care Service Plan Act of 1975, Health & Safety Code, Sections 1340 *et seq.*
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.
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.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Member	A beneficiary who is enrolled in a CalOptima program.

Term	Definition
Regulatory Agencies	For the purposes of this policy regulatory agencies include Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Health and Human Services Office of Inspector General (OIG) and Office of Civil Rights (OCR).
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.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.2027Δ
Title:	**Annual Risk Assessment (Delegate)**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	12/06/18
Last Revised Date:	12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the Annual Risk Assessment process conducted by CalOptima's Audit & Oversight Department to identify delegated First Tier Entities' (FTEs) specific functional areas vulnerable to potential compliance risk. Such areas are documented in CalOptima's risk assessment, which will influence the development of CalOptima's delegated FTE's audit and monitoring work plan.

II. POLICY

A. CalOptima maintains ultimate responsibility for adhering to and otherwise fully complying with its contract with the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS). CalOptima is required to establish and implement an effective system of routine monitoring and identification of compliance risks.

B. At least annually, the Audit & Oversight Department is responsible for completing a Annual Risk Assessment to develop its delegated FTE audit and monitoring work plan that ensures CalOptima's regulatory obligations are met. In assessing risk, the Audit & Oversight Department shall consider the following:

1. Statutory, regulatory, and contractual standards;

2. CalOptima's policies and procedures;

3. Business impact on Member care; and

4. Past compliance issues.

C. CalOptima shall, through contract or appropriate written arrangements, require the FTEs to conduct risk assessments, at least annually, and ongoing monitoring and audit of the Downstream Entities with which they contract to ensure compliance. CalOptima shall retain the right to conduct its own risk assessments and ongoing monitoring and audit of the Downstream Entities to ensure compliance.

D. The Audit & Oversight Department shall stay current with all regulatory communication and guidance from the Regulatory Agencies.

E. The Audit & Oversight Department shall present Annual Risk Assessment results and the proposed FTE audit and monitoring work plan to both the Audit & Oversight Committee (AOC) and the Compliance Committee for review and approval by the end of the calendar year to be effective for the following year.

III. PROCEDURE

A. The Audit & Oversight Department shall undertake a discovery process of the FTEs, consisting of a document review to determine how regulatory, statutory, contractual, and CalOptima policy requirements are implemented; the operational effectiveness, and how the practices and the documentation support compliance. The analysis component of the Annual Risk Assessment is based on the evaluation of the FTEs' performance during the previous calendar year, including but not limited to monthly monitoring results, annual audit results and focused reviews when applicable.

1. In the event that the FTE is a new delegate, the Audit & Oversight Department shall audit the First Tier Entity to collect baseline data in accordance with CalOptima Policy GG.1619: Delegation Oversight.

B. The Audit & Oversight Department shall consider the following information as it applies to FTEs, as part of the Annual Risk Assessment process:

1. A particular area identified by a Regulatory Agency as problematic through enforcement actions that may impact CalOptima, including but not limited to, National Committee for Quality Assurance (NCQA) status;

2. Regulatory audit findings;

3. CalOptima monitoring and audit findings;

4. Regulatory notices of non-compliance;

5. A completed questionnaire by the following CalOptima departments: (i) Regulatory Affairs and Compliance, (ii) Quality Improvement, (iii) Grievance and Appeals Resolution Services, (iv) Privacy, (v) Fraud, Waste & Abuse, and (vi) the business owner to provide knowledge of issues or trends being identified throughout CalOptima.

6. Accuracy of delegate encounter data, submissions, coding, medical loss ratio (MLR) reported data, and other areas that may impact CalOptima payments (e.g., MLR, Hierarchical Condition Category (HCC) risk scores);

7. Whether there is a Corrective Action Plan (CAP) in effect, and if so, its relative risk for the non-compliance area; and

8. Whether the FTEs are applying appropriate compliance program requirements to the Downstream Entities with which they contract, conducting risk assessments, at least annually, and performing ongoing monitoring and auditing of such Downstream Entities to ensure compliance.

C. The Audit & Oversight Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment audits evaluating file reviews, data collected from ongoing monitoring results, annual audit results, and number of CAPs issued during the review period.

1. The Audit & Oversight Department shall compile the data and rank the risks based on the greatest impact on delegated operations and quality health care delivery to CalOptima Members.

D. The Audit & Oversight Department shall present the FTE risk assessment results and proposed audit and monitoring work plan to the AOC and subsequently to the Compliance Committee for approval.

E. The Audit & Oversight Department shall re-evaluate the work plan based on internal changes for approval (e.g., staffing and organizational structure changes, audit results, monitoring results, etc.) and external changes (e.g., regulatory changes, marketplace changes, Regulatory Agency audit results, etc.).

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
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VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	MA.9117	Annual Risk Assessment	OneCare
Revised	11/01/2014	MA.9117	Annual Risk Assessment	OneCare
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IX. GLOSSARY

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Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy #:	HH.3001Δ
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	~~12/07/17~~12/06/18
Last Revised Date:	~~12/07/17~~12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) for a Member, maintained by CalOptima and the conditions under which the Member may access, inspect, or obtain a copy of his or her PHI in the DRS.

II. POLICY

A. Except as otherwise provided in Section III.A.9 of this Policy, Members shall have the right ~~to~~of access~~,~~ to inspect~~, or~~ and obtain a copy of their PHI in the DRS for as long as CalOptima maintains the PHI ~~record~~in the DRS.

1. Records are retained in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

B. CalOptima shall provide a Member with access to their PHI in the format requested by the Member, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima and the Member.

C. If the Member requests their PHI to be sent via mail, CalOptima may impose a reasonable, cost-based fee for postage.

D. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policies HH.3009Δ: Access by Member's Personal Representative and HH.3015Δ: Member Authorization for ~~Release~~the Use and Disclosure of Protected Health Information.

E. Any person with knowledge of a violation, or potential violation, of this policy shall report such information to the Privacy Officer directly, or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 or email: privacy@caloptima.org.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of DRS:

1. A Member shall submit a written request for access to inspect or obtain a copy of his or her PHI in the DRS by submitting the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form to the Office of Compliance. A Member's Personal Representative may request access to the Member's PHI in accordance with the requirements set forth in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.

2. The DRS does not include complete copies of records created and/or maintained by Providers or entities other than CalOptima. If a Member wants such records, they are advised to contact their doctor, Health Network, or other health care provider.

3. CalOptima shall process a request to access, inspect or obtain copies of the DRS within thirty (30) calendar days after receipt of a complete written request.

4. If necessary, a thirty (30) calendar day extension may be used to retrieve information that is not readily available.

   a. For ~~extensions~~an extension, CalOptima must provide the Member, within thirty (30) calendar days after receipt of the request, a written statement of the reasons for the delay and the date by which it ~~may~~will complete its action ~~within the thirty (30) calendar day period~~on the request .

   b. CalOptima may only have one (1) such extension of time for action on a request for access to DRS.

5. The Office of Compliance shall notify the Member, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this policy.

6. Verification of Member identification requesting access to inspect or copy the DRS:

   a. If the Member makes such request in person to the Customer Service Department, Customer Service staff shall:

      i. Request identification (e.g., Driver License or Member ID card), or ask to verify the Member's date of birth or address based on FACETS™ data; and

      ii. Provide the Member with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the ~~Designated Record Set~~DRS Form for the Member to complete.

   b. If the Member request is received by mail or fax, the Office of Compliance staff shall verify the identity of the individual in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

7. The Office of Compliance shall accept the request from the Member as valid, provided all information on the request is complete and accurate. All requests shall include, as applicable:

   a. An Authorization for Release of Protected Health Information Form, as applicable, for Disclosure of a Member's PHI to a third party;

b. An Individual Request for Access to Protected Health Information (PHI) Contained in the ~~Designated Record Set~~DRS Form;

c. A written request that provides sufficient information, as necessary to identify the specific PHI sought;

d. Documentation that verifies the identity of the Member, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

8. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access.

9. The Office of Compliance shall deny Member access ~~to~~in the following circumstances:

~~a. Patient identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose;~~

a. PHI that is not part of a ~~Designated Record Set~~DRS because the information is not used to make decisions about Members;

b. Psychotherapy ~~notes~~Notes;

c. PHI compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action, or proceeding; ~~or~~

d. A CalOptima PACE covered health care provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of PHI, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate;

e. A Member's access to PHI created or obtained by a CalOptima PACE covered health care provider in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress, provided that the Member has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered health care provider has informed the Member that the right of access ~~with the~~will be reinstated upon completion of the research;

f. With respect to CalOptima OneCare Connect Program, a Member's access to PHI that is contained in records that are subject to the Privacy Act, 5 USC § 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law;

~~d.~~g. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

~~e.~~h. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the Member, or another person;

f. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional has determined, in his or her professional

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judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

g. The ~~Authorized~~Personal Representative requests for access, and a licensed health care professional has determined, in his or her professional judgment, that the provision of access to such Personal Representative is reasonably likely to cause substantial harm to the individual, or another person.

10. If the denial is based on any of the reasons as stated in Section III.A.9 ~~e – g,~~h – j., a Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer at 505 City Parkway West, Orange, CA 92868.

11. The Office of Compliance shall route the request to the department(s), or Business Associate responsible for creating, or maintaining, the requested record(s).

12. The responsible department~~, or~~ shall send a copy of the requested PHI to the Office of Compliance within seven (7) calendar days of receiving the request.

~~12.~~ The Business Associate~~,~~ shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

13.

B. The following departments within CalOptima shall have responsibility for the DRS~~, as follows~~:

1. Customer Service;
2. Information Systems;
3. Claims Administration;
4. Utilization Management;
5. Case Management;
6. Pharmacy;
7. Grievance and Appeals Resolution Services;
8. Enrollment;
9. Multipurpose Senior Services Program (MSSP); ~~and~~

~~10. Long Term Care (LTC).);~~

10. Long Term Services and Supports (LTSS);

11. Health ~~and~~ Education and Disease Management; and

12. Behavioral Health.

C. Department staff shall consult the Privacy Officer if there is any doubt about the appropriateness of Member access to inspect or copy PHI from the DRS.

D. If CalOptima does not maintain the PHI that is the subject of the Member's request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the Member of the entity to whom the Member may direct such request.

E. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

a. Approved: If CalOptima approves the Member's request, CalOptima shall provide the Member with the records requested, in accordance with the format and method designated on the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

b. Denied: If CalOptima denies the Member's request, CalOptima shall send a letter to the Member within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a Member may complain to CalOptima, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima.

c. Approved or denied, in whole or in part: If CalOptima approves a portion of the Member's request and also denies portion of the request, CalOptima shall provide the Member with the records requested in accordance with Section III.E.1.a of this Policy. CalOptima shall also provide a letter informing the Member of the denial, in accordance with Section III.E.1.b of this policy.

F. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the Member, for ten (10) years from the date of the release.

G. Designated Record Set Content

~~G.~~1. The ~~following table summarizes the~~ content of CalOptima's DRS~~:~~ can be found in the Designated Record Set Matrix (Attachment A)

~~DRS Content~~	~~Source~~	~~Media Type For Member~~
~~Enrollment Form from Member~~ ~~Auto-Assignment and Health Network changes~~ ~~*(Not applicable to Medi-Cal members)*~~	~~Customer Service~~ ~~Customer Service~~	~~Paper Form~~ ~~Print-out/report from FACETS™~~ ~~Excluded: Customer Service Notes and Call Recordings~~

~~DRS Content~~	~~Source~~	~~Media Type For Member~~
~~(1) Eligibility Records~~	~~Customer Service~~	~~Print out/report from FACETS™~~
~~(2) Claims Records~~	~~Claims~~	~~Print out/report from FACETS™~~
~~(3) Prior, current and retrospective Authorization Records (ARF/PA request and attachments, notice of action (NOA) letters)~~	~~Utilization Management~~	~~Print out/report from FACETS™, clinical systems. Paper copy from ARF/PA File~~
~~(4) Prior, current and retrospective Authorization Records (Pharmacy)~~ ~~(5) Grievance and Appeals Resolution letters (Pharmacy)~~	~~Pharmacy~~	~~Paper copy~~ ~~Summary Pharmacy Benefit Manager (PBM) data files~~
~~(6) Prior Authorization Records~~	~~MSSP~~ ~~LTC~~	~~Paper copy~~ ~~Print out/report from MSSP database~~ ~~Paper copy, Print out/report from LTC database~~
~~Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the Member.~~	~~Case Management~~	~~Paper copy~~ ~~Summary reports from clinical systems and data base files.~~ ~~Excludes: Case or medical management notes created by Providers or Health Networks.~~
~~**Excluded:**~~ ~~Patient identifiable data used for administrative, regulatory, Health Care Operations and Payment/financial purpose; employment records held by CalOptima in its role as employer.~~		~~Examples include protocols, practice guidelines, accreditation reports, best practice guidelines, public health records, statistical reports, MDS Report, patient identifiable data reviewed for quality assurance, call recordings and internal department notes (e.g. Customer Service notes).~~

IV. ATTACHMENTS

A. Designated Record Set Matrix
~~A.~~B. Authorization for Release of Protected Health Information (PHI)
~~B.~~C. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
~~C.~~D. Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set
~~D.~~E. Letter: Denial of Access-Subject to review
~~E.~~F. Letter: Denial of Access-Not Subject to review

V. REFERENCES

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 PACE Program Agreement
E. CalOptima Notice of Privacy Practices
F. CalOptima Policy HH.2022Δ: Record Retention and Access
G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
H. CalOptima Policy HH.3004Δ: Member Request to Amend Records
~~H.~~I. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
~~I.~~J. CalOptima Policy HH.3015Δ: Member Authorization for ~~Release~~the Use and Disclosure of Protected Health Information (PHI)
~~J.~~K. CalOptima Privacy Program
~~K.~~L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~L.~~M. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 2 – 2017
~~M.~~N. Title 45, Code of Federal Regulations (C.F.R.), §164.501
~~N.~~O. Title 45, Code of Federal Regulations (C.F.R.), §164.524
~~O.~~P. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Effective	08/01/2005	MA.9203	Member Access to Designated Record Set	OneCare
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2008	MA.9203	Member Access to Designated Record Set	OneCare
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	MA.9203	Member Access to Designated Record Set	OneCare

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Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	06/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	MA.9203	Member Access to Designated Record Set	OneCare
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9203	Member Access to Designated Record Set	OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3001Δ	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
Designated Record Set	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care provider; 2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
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	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Psychotherapy Notes	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Member's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Policy #:	HH.3001Δ
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/06/18
Last Revised Date:	12/06/18

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) for a Member, maintained by CalOptima and the conditions under which the Member may access, inspect, or obtain a copy of his or her PHI in the DRS.

II. POLICY

A. Except as otherwise provided in Section III.A.9 of this Policy, Members shall have the right of access to inspect and obtain a copy of their PHI in the DRS for as long as CalOptima maintains the PHI in the DRS.

1. Records are retained in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

B. CalOptima shall provide a Member with access to their PHI in the format requested by the Member, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima and the Member.

C. If the Member requests their PHI to be sent via mail, CalOptima may impose a reasonable, cost-based fee for postage.

D. CalOptima shall grant a Member's Authorized Representative access to a Member's PHI, in accordance with CalOptima Policies HH.3009Δ: Access by Member's Personal Representative and HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information.

E. Any person with knowledge of a violation, or potential violation, of this policy shall report such information to the Privacy Officer directly, or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 or email: privacy@caloptima.org.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of DRS:

1. A Member shall submit a written request for access to inspect or obtain a copy of his or her PHI in the DRS by submitting the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form to the Office of Compliance. A Member's Personal Representative may request access to the Member's PHI in accordance with the requirements set forth in CalOptima Policy HH.3009Δ: Access by Member's Personal Representative.

2. The DRS does not include complete copies of records created and/or maintained by Providers or entities other than CalOptima. If a Member wants such records, they are advised to contact their doctor, Health Network, or other health care provider.

3. CalOptima shall process a request to access, inspect or obtain copies of the DRS within thirty (30) calendar days after receipt of a complete written request.

4. If necessary, a thirty (30) calendar day extension may be used to retrieve information that is not readily available.

    a. For an extension, CalOptima must provide the Member, within thirty (30) calendar days after receipt of the request, a written statement of the reasons for the delay and the date by which it will complete its action on the request .

    b. CalOptima may only have one (1) such extension of time for action on a request for access to DRS.

5. The Office of Compliance shall notify the Member, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this policy.

6. Verification of Member identification requesting access to inspect or copy the DRS:

    a. If the Member makes such request in person to the Customer Service Department, Customer Service staff shall:

        i. Request identification (e.g., Driver License or Member ID card), or ask to verify the Member's date of birth or address based on FACETS™ data; and

        ii. Provide the Member with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the DRS Form for the Member to complete.

    b. If the Member request is received by mail or fax, the Office of Compliance staff shall verify the identity of the individual in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

7. The Office of Compliance shall accept the request from the Member as valid, provided all information on the request is complete and accurate. All requests shall include, as applicable:

    a. An Authorization for Release of Protected Health Information Form, as applicable, for Disclosure of a Member's PHI to a third party;

    b. An Individual Request for Access to Protected Health Information (PHI) Contained in the DRS Form;

c. A written request that provides sufficient information, as necessary to identify the specific PHI sought;

d. Documentation that verifies the identity of the Member, in accordance with CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information.

8. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access.

9. The Office of Compliance shall deny Member access in the following circumstances:

a. PHI that is not part of a DRS because the information is not used to make decisions about Members;

b. Psychotherapy Notes;

c. PHI compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action, or proceeding;

d. A CalOptima PACE covered health care provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of PHI, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate;

e. A Member's access to PHI created or obtained by a CalOptima PACE covered health care provider in the course of research that includes treatment may be temporarily suspended for as long as the research is in progress, provided that the Member has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered health care provider has informed the Member that the right of access will be reinstated upon completion of the research;

f. With respect to CalOptima OneCare Connect Program, a Member's access to PHI that is contained in records that are subject to the Privacy Act, 5 USC § 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law;

g. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

h. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the Member, or another person;

f. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

g. The Personal Representative requests for access, and a licensed health care professional has determined, in his or her professional judgment, that the provision of access to such Personal

Representative is reasonably likely to cause substantial harm to the individual, or another person.

10. If the denial is based on any of the reasons as stated in Section III.A.9 h – j., a Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Privacy Officer at 505 City Parkway West, Orange, CA 92868.

11. The Office of Compliance shall route the request to the department(s), or Business Associate responsible for creating, or maintaining, the requested record(s).

12. The responsible department shall send a copy of the requested PHI to the Office of Compliance within seven (7) calendar days of receiving the request.

13. The Business Associate shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

B. The following departments within CalOptima shall have responsibility for the DRS:

1. Customer Service;
2. Information Systems;
3. Claims Administration;
4. Utilization Management;
5. Case Management;
6. Pharmacy;
7. Grievance and Appeals Resolution Services;
8. Enrollment;
9. Multipurpose Senior Services Program (MSSP);
10. Long Term Services and Supports (LTSS);
11. Health Education and Disease Management; and
12. Behavioral Health.

C. Department staff shall consult the Privacy Officer if there is any doubt about the appropriateness of Member access to inspect or copy PHI from the DRS.

D. If CalOptima does not maintain the PHI that is the subject of the Member's request for access, and CalOptima knows where the requested information is maintained, CalOptima shall inform the Member of the entity to whom the Member may direct such request.

E. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

   a. Approved: If CalOptima approves the Member's request, CalOptima shall provide the Member with the records requested, in accordance with the format and method designated on the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set Form within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

   b. Denied: If CalOptima denies the Member's request, CalOptima shall send a letter to the Member within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a Member may complain to CalOptima, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima.

   c. Approved or denied, in whole or in part: If CalOptima approves a portion of the Member's request and also denies portion of the request, CalOptima shall provide the Member with the records requested in accordance with Section III.E.1.a of this Policy. CalOptima shall also provide a letter informing the Member of the denial, in accordance with Section III.E.1.b of this policy.

F. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the Member, for ten (10) years from the date of the release.

G. Designated Record Set Content

1. The content of CalOptima's DRS can be found in the Designated Record Set Matrix (Attachment A)

IV. ATTACHMENTS

A. Designated Record Set Matrix
B. Authorization for Release of Protected Health Information (PHI)
C. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form
D. Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set
E. Letter: Denial of Access-Subject to review
F. Letter: Denial of Access-Not Subject to review

V. REFERENCES

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 PACE Program Agreement
E. CalOptima Notice of Privacy Practices

F. CalOptima Policy HH.2022Δ: Record Retention and Access
G. CalOptima Policy HH.3003Δ: Verification of Identity for Disclosure of Protected Health Information
H. CalOptima Policy HH.3004Δ: Member Request to Amend Records
I. CalOptima Policy HH.3009Δ: Access by Member's Authorized Representative
J. CalOptima Policy HH.3015Δ: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
K. CalOptima Privacy Program
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 2 – 2017
N. Title 45, Code of Federal Regulations (C.F.R.), §164.501
O. Title 45, Code of Federal Regulations (C.F.R.), §164.524
P. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

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Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Designated Record Set Matrix		
DRS Content	**Source**	**Media Type For Member**
(1) Enrollment Form from Member (CalOptima does not maintain such forms for Medi-Cal Members)	Customer Service	Enrollment Form (signed)
(2) Auto-Assignment and Health Network changes	Customer Service	Print out/report from FACETS™ of health network changes.
(3) Eligibility Records	Customer Service	Screenshot of member eligibility history.
(4) Customer Service Task Notes	Customer Service	CORE Report
(5) Claims Records (Medical and Pharmacy Claims)	Claims	Health Insurance Claim Forms, Remittance Advices, documentation submitted with claim forms
	Pharmacy	CalOptima Pharmacy Claims CORE Report
(6) Prior, Current and Retrospective Authorization Records (ARF/PA request and attachments, notice of action (NOA) letters)	Utilization Management	Authorization and denial letters from GuidingCare and/ or Summary report from CCMS system.
(7) Prior, current and retrospective Authorization Records (Pharmacy)	Pharmacy	Authorization and denial letters from Pharmacy Benefit Manager (PBM) files. GuidingCare and/ or Summary report from CCMS system.
(8) Grievance and Appeals Resolution letters State Hearing Letters	GARS	<u>Grievance file</u> Acknowledgement Letter Resolution Letter If any medical records are obtained <u>Appeal File</u> Acknowledgement Letter Resolution Letter Medical Records Notice of Action State Hearing Records 14 day extension letter, if applicable Print out/report from Guiding Care and/or GARS database

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Designated Record Set Matrix		
DRS Content	**Source**	**Media Type For Member**
(9) Prior Authorization Records Care Plans and Assessments.	MSSP	Print out/report from Guiding Care and/or MSSP database
	LTSS	Print out/report from Guiding Care and/or LTSS database
	LTC	Print out/report from Guiding Care and/or LTC database
(10) Care Plan Records, Assessments, and Notes	Health Education and Disease Management	Print out/report from GuidingCare and/or Health Education and Disease Management Database.
(11) Behavioral Health Authorizations and Denials, Care Management Notes	Behavioral Health	Print out/report from GuidingCare
(12) Entries in Care Management Data Systems including contacts with Member or other coordination activities used in making decisions about the M... b	Case Management	Paper copy Summary reports from clinical systems and data base files.
(13) Durable Medical Equipment (DME) Assessments	MSSP/ Utilization Management	Paper copy from clinical systems and data base files.
Employment records held by CalOptima in its role as an employer are not PHI, and therefore are not subject to the HIPAA Privacy Rule. In addition, a Member does not have a right of access to PHI that is not part of a Designated Record Set because the information is not used to make a decisions about Members. Examples include: quality assurance records, accrediation reports, statistical reports (and any related internal department notes and call recordings).		

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Fill out **ALL** sections of this form to allow CalOptima to release your protected health information (PHI) to another person or agency. This form is **ONLY** to release the information. It will not allow anyone to make health care decisions for you.

SECTION A: Member Information

Last Name: _____ First Name: _____

CIN: _____ Date of Birth: _____ *mm/dd/yyyy*

Address: _____
Street/Unit Number *City* *State* *Zip Code*

Best phone number to contact you: _____

Instructions: Mark X inside the box next to your selected option.

SECTION B: Information That Can Be Released

I allow CalOptima to release:

☐ Any and all of my PHI

☐ Only release the following: (list what you allow):

_____

_____

I allow the release of PHI about:
(Initial if any of the below boxes are checked)

☐ Mental health treatment Initial:_____
☐ Alcohol / drug treatment Initial:_____

NOTE: These details will not be released unless you approve first.

SECTION C: Purpose of Authorization

I am releasing this information for:

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (please specify.): _____

SECTION D: Person(s) or Agency Allowed to Get PHI

I allow CalOptima to release my PHI to the person or agency below. I know this authorization starts when I sign and return this form. The person getting the information must be 18 years of age or older.

Person /Agency's Name(s): _____

Relationship to Member: _____ Phone: _____

SECTION E: My Rights

- I may stop this authorization at any time by sending a **written** notice to: CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange, CA 92868.
- Notice to stop this authorization will not change how CalOptima used or released my PHI before getting my letter.
- The person or agency who gets my PHI from CalOptima may show it to others. In this case, my PHI may no longer be protected by HIPAA Privacy Rules.
- I do not have to fill out this form. Not filling out this form will not change my health care benefits or payment for my health care services.
- I have the right to look at or get a copy of my PHI that is being used or released by this authorization.
- I have the right to get a copy of this form.

SECTION F: End Date of Approval

This authorization for release of information to the named persons or agency will end on: _____ (specific date or event).

**** If an end date or event is not provided, the authorization will not be valid. ****

SECTION G: Signature

I understand that to process my request, a copy of valid government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be attached with my request form.

By signing below, I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

CalOptima reserves the right to request legal documentation (e.g., birth certificate, court order, etc.) from the parent/guardian signing on behalf of a dependent member.

Personal Representatives Only: What rights do you have to request health information?

Print Name: _____

- ☐ Conservator
- ☐ Executor of Will
- ☐ Administrator of Estate
- ☐ Medical Power of Attorney
- ☐ Other_____

NOTE: You must attach legal documentation to verify that you are the conservator, executor of a decedent's will, or have medical decision-making authority for the individual.

Please mail this form to CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange CA 92868, or fax it to **1-714-338-3104**.

STOP

For CalOptima Use Only:

Staff Name: _____ How was identity verified? In person/Phone

Signature: Date verified:

INSTRUCTION SHEET FOR CALOPTIMA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION C: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under **"Other"** and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION D: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION F: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, ***"one year from my signature date."***

SECTION G: SIGNATURE

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
  - **Power of Attorney for Health Care —** this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
  - **Legal Guardianship —** this is when the court appoints someone to care for another person.
  - **Conservatorship of the Person —** this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
  - **Executor of Estate —** this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

INDIVIDUAL REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI) CONTAINED IN THE DESIGNATED RECORD SET (DRS)

You have the right to inspect your protected health information (PHI) in the Designated Record Set (DRS). You also have the right to request copies of those records. You will receive a response to your request within 30 days after we receive the completed form. If the information is not readily available, CalOptima has up to 60 days to provide you with your PHI. CalOptima may charge a fee of $0.10 per page and any postage fees if you ask for copies of the records to be mailed to you.

To Request a Copy of Your PHI in a DRS:

1. Fill out the entire form and print clearly. **In order to process your request, a photocopy of your valid photo identification (ID) must be included with your request form.**

2. If you would like to appoint another person to have access to or receive your PHI, then you must also complete the CalOptima Authorization for Release of Protected Health Information form. Requests by your personal representative are subject to verification.

3. Please select the type of records you need from the list provided. If you are not sure what you need, please call CalOptima Customer Service toll-free at **1-888-587-8088** for help. .

4. If you were a part of a health network (e.g. Monarch, AltaMed, etc.) during any part of the date range requested, you should also contact that health network. **CalOptima does not have complete copies of your medical records. If you want to look at or get a copy of your medical records, please contact your doctor or clinic.**

5. If you have any questions about your request, please call CalOptima Customer Service toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. TDD/TTY users can call toll-free at **1-800-735-2929**. We have staff who speak your language.

6. Your records may be picked up at CalOptima's office or sent via email or certified postal mail. Requests for records to be faxed must be approved by CalOptima. Records sent via email will be sent secure (encrypted) to the email address provided. However, CalOptima is not responsible for loss of PHI on personal email accounts.

INDIVIDUAL REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI) CONTAINED IN THE DESIGNATED RECORD SET (DRS)

Member Name: _____ Date of Birth: _____ *(mm/dd/yyyy)*

Phone: (____) _____ CalOptima CIN: _____

The types of records listed below are part of the DRS maintained by CalOptima. Please select the types of records you wish to view or receive as well as the date range.

Authorizations
- ☐ Medical Authorization Request(s)
- ☐ Pharmacy Prior Authorization(s) (PA)
- ☐ Notice of Action(s)

Behavioral Health Record(s)
- ☐ Behavioral Health Authorization(s)/Denials
- ☐ Care Management Notes

Case Management
- ☐ Case Management Note(s)
- ☐ Case Management Care Plan(s)
- ☐ Case Management Assessment(s)

Claims/Billing
- ☐ Medical Claims Record(s)
- ☐ Pharmacy Claims Record(s)

Customer Service
- ☐ Member Call Logs

Eligibility
- ☐ Eligibility Record(s)
- ☐ Auto Assignment and Health Network Changes
- ☐ Enrollment Form(s) (Does not apply to Medi-Cal Members)

Grievances and Appeals (GARS)
- ☐ Grievance Case File Record(s)
- ☐ Appeal Case File Record(s)

Health Education and Disease Management
- ☐ Care Plan(s)
- ☐ Assessment(s)
- ☐ Health Ed. and Disease Mgmt. Notes

Long-Term Services and Supports (LTSS)
- ☐ Assessment(s)
- ☐ Authorization(s)
- ☐ Case Management Notes

Multipurpose Senior Services Program (MSSP)
- ☐ Assessment(s)
- ☐ Care Plan(s)
- ☐ Referral Form(s)
- ☐ Progress Notes
- ☐ Application Form

State Hearing(s)
- ☐ State Hearing Record(s)

I am requesting copies of records for the following dates of service: _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Requests submitted without a date range will be considered incomplete.

Delivery method requested (select one):

☐ "Personal" pickup at CalOptima (identification required at the time of pickup)

☐ Mail: _____
Street/Unit *City* *State* *ZIP Code*

☐ Fax (Upon approval): (____) _____ ☐ Email: _____

Identifying information is required (select one):

☐ Copy of ID attached (e.g. valid driver license, birth certificate, benefits ID card, etc.)

☐ If no ID is attached, your signature must be notarized.

Notarized By: _____

Notary Public Number: _____

Date: _____

Unofficial Unless Stamped by Notary Public

Signature Block:

(I understand that to process my request, a copy of valid, government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be included with my request form.)

By signing below, I state that I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

CalOptima reserves the right to request legal documentation (e.g., birth certificate, court order, etc.) from the parent/guardian signing on behalf of a dependent member.

Personal Representatives — Please attach legal documentation to verify that you are the conservator, executor of a decedent's will, or have medical decision-making authority for the individual.

Submit the completed and signed request form and copy of ID to CalOptima, either in person, by mail or by fax.

CalOptima
Attn: Office of Compliance (Privacy)
505 City Parkway West, Orange, CA 92868
Fax: 1-714-481-6457

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE], regarding the above named member. A licensed healthcare professional has reviewed this request, and has denied access to the information. Under federal law, we are not required to provide the information because [REASON].

If you wish to have the denial reviewed by another licensed health care professional, you may submit a written request for review. This request should be submitted to:

CalOptima Privacy Officer
505 City Parkway West
Orange, CA, 92868

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer
CalOptima

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Member Name:
Member CIN:

Re: Response to Request for Access to Protected Health Information (PHI)

Dear [NAME]:

CalOptima has received your request for access to Protected Health Information (PHI) dated [DATE] regarding the above named member. A licensed healthcare professional has reviewed this request and denied access to the information. Under federal law, we are not required to provide the information because [REASON].

This denial is final and is not subject to review according to federal law.

Should you have any questions regarding this denial, you may contact the Office of Compliance at CalOptima by calling [Number].

For more information about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It is also available on our website at www.caloptima.org, or from CalOptima's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-714-246-8523**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima, contact CalOptima's Customer Service Department at 1-714-246-8500.

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

Privacy Officer
CalOptima

Policy #:	HH.3003Δ
Title:	**Verification of Identity for Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	~~12/07/17~~12/06/18
Last Revised Date:	~~12/07/17~~12/06/18

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy defines the steps necessary for verification of identity of a person requesting Protected Health Information (PHI) prior to Disclosure.

II. POLICY

A. CalOptima, and its programs, shall make every reasonable effort to verify the identity and legal authority of a person requesting Disclosure of PHI.

III. PROCEDURE

A. Verification of a Member:

1. Telephone: A person representing him or herself to be a Member can be verified using the following method:

   a. Demographic information that is confirmed in FACETS™ (Member number, address, or date of birth);

   b. The use of confirming data in the system such as prior entries regarding services; or

   c. The Member is known to CalOptima staff from prior contact.

2. In person: A person representing him or herself to be a Member can be verified by:

   a. Presentation of identification (ID) such as a valid driver license, CalOptima identification card, or other valid, government-issued identification.

   b. Verbal statements of address, date of birth, or other data confirmed in FACETS™; or

   c. The Member is known to CalOptima staff from prior contact.

3. Written request: A person representing him or herself to be a Member in a written request can be verified by:

   a. Submitting a copy of a government issued identification, such as a driver license, a state issued identification (ID) card, or a passport; or

   b. A written request or authorization form with a notarized signature.

B. Verification of a Member's Personal Representative:

1. Telephone and in-person: A Personal Representative shall provide information to identify his or her relationship to the Member in question. Accepted documents include:

   a. Legal documents: Executed power of attorney, proof of guardianship, medical power of attorney, certified letter of conservatorship, executor of will, letters testamentary, or letters of administration, or if the Member is deceased and the Personal Representative is the next of kin or other family member, accepted documentation may be the Personal Representative's birth certificate and driver's license; or

   b. A valid written authorization signed by the Member (signature must either be notarized, or a copy of a government issued identification must accompany the authorization) or the court.

2. Written request made by a Personal Representative: A Personal Representative shall include legal documentation with his or her written request to verify that he or she is the parent, conservator, guardian, executor of a decedent's will, or has medical decision making-authority for the individual, along with a notarized signature, or government issued identification of the Personal Representative.

3. Documentation of the Personal Representative's known relationship shall be documented in FACETS™ and the documentation provided by the Personal Representative shall be saved in the Customer Service Department shared files.

4. CalOptima shall grant a Member's Personal Representative access to a Member's PHI, in accordance with the following CalOptima Policies HH.3001Δ: Member Access to Designated Record Set, HH.3009Δ: Access by Member's Personal Representative, and HH.3015Δ: Authorization for Release of Protected Health Information.

C. Verification of a Disclosure requested by a family member, relative, close friend of the Member, or any other person identified by the Member:

1. Member is available: If the Member is available on the telephone or in person, CalOptima staff shall obtain the Member's consent before disclosing the PHI, or based on the circumstances, if it is inferred that the Member was given the opportunity to object and did not object to the Disclosure. Documentation of the Disclosure is required as follows:

   a. CalOptima staff shall document that the Member was present and verbally agreed to the Disclosure; or

b. The circumstances that led the CalOptima staff to believe that the Member agreed to, or did not object to, the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

2. Member is not available: If there is an emergency, or if the Member is incapacitated, CalOptima staff may use their professional judgment to determine whether the Disclosure of PHI is in the best interest of the Member. Staff may only disclose the PHI that is relevant to the person's involvement in the Member's care and shall document the emergency that supported the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

a. CalOptima staff shall adhere to applicable state and federal regulations regarding minimum necessary uses and Disclosures of PHI, as well as CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information.

D. Written Requests for PHI:

1. A written request for copies of PHI may be accepted as valid, provided all information on the request is complete and accurate based on CalOptima data, subject to the verification requirements above.

2. A written request for copies of a minor's PHI may be accepted if the request is accompanied with valid legal documentation verifying that the requestor is the minor's Personal Representative.

~~2.~~3. A request from a Member's Personal Representative shall include either the appropriate legal documentation or written authorization from the Member to release the PHI, (signature must either be notarized or a copy of a government issued identification must accompany the authorization), unless otherwise permitted, in accordance with the following CalOptima Policies HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations, and HH.3010Δ: Protected Health Information Disclosures Required by Law.

3. Deceased Member: The PHI of a deceased Member is subject to the federal HIPAA privacy provisions for as long as CalOptima maintains the PHI. A Personal Representative with legal authority to act on behalf of a deceased Member or their estate may request the Member's PHI.

4. CalOptima shall verify the legal authority of a public official or person acting on behalf of a public official through a review of:

a. Documentation, statements, or presentations that, upon initial review, meet the applicable requirements for a Disclosure of PHI;

b. Presentation of an agency identification badge, other official credentials, or other proof of government authority;

c. Other evidence or documentation from an agency which establishes that the person is acting on behalf of the public official, such as a contract for services, memorandum of understanding, or purchase order;

d. A written statement of legal authority under which the information is requested;

e. If a written statement is impracticable, an oral statement of such legal authority; or

f. A request that is made pursuant to a warrant, subpoena, order, or other legal process issued by a grand jury, or a judicial or administrative tribunal, that is presumed to constitute legal authority.

E. Avert Serious Threat to Health or Safety. The verification requirements are met if CalOptima staff ~~may rely~~acts on ~~the exercise of professional judgment~~good faith belief in making a Disclosure ~~to avert~~as follows:

1. Consistent with applicable law and standards of ethical conduct, CalOptima staff may Disclose PHI if staff in good faith believes the Disclosure:

a. Is necessary to prevent or lessen a serious and imminent threat to the health ~~and~~or safety of a ~~Member~~person or ~~others~~the public; and

b. Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

~~E.~~2. CalOptima staff shall document the circumstances regarding his or her good faith belief, including whether the belief is based on staff's actual knowledge or reliance on a credible representation by a person with apparent knowledge or authority.

IV. ATTACHMENTS

A. Authorization for Release of Protected Health Information (PHI)
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreement
D. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set
E. CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls
F. CalOptima Policy HH.3009Δ: Access by Member's Personal Representative
G. CalOptima Policy HH.3010Δ: Protected Health Information Disclosures Required by Law
H. CalOptima Policy HH.3011Δ: Use and Disclosure for Treatment, Payment and Health Care Operations

I. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~J.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
K. Title 45, Code of Federal Regulations (C.F.R), §164.514(h)
L. Title 45, Code of Federal Regulations (C.F.R), §164.510(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	04/01/2007	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	12/01/2011	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	09/01/2014	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized/Personal Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by Member's Personal Representative.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Member	A beneficiary who is enrolled in a CalOptima Program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

Policy #:	HH.3003Δ
Title:	**Verification of Identity for Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/06/18
Last Revised Date:	12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy defines the steps necessary for verification of identity of a person requesting Protected Health Information (PHI) prior to Disclosure.

II. POLICY

A. CalOptima, and its programs, shall make every reasonable effort to verify the identity and legal authority of a person requesting Disclosure of PHI.

III. PROCEDURE

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1. Telephone: A person representing him or herself to be a Member can be verified using the following method:

   a. Demographic information that is confirmed in FACETS™ (Member number, address, or date of birth);

   b. The use of confirming data in the system such as prior entries regarding services; or

   c. The Member is known to CalOptima staff from prior contact.

2. In person: A person representing him or herself to be a Member can be verified by:

   a. Presentation of identification (ID) such as a valid driver license, CalOptima identification card, or other valid, government-issued identification.

   b. Verbal statements of address, date of birth, or other data confirmed in FACETS™; or

   c. The Member is known to CalOptima staff from prior contact.

3. Written request: A person representing him or herself to be a Member in a written request can be verified by:

   a. Submitting a copy of a government issued identification, such as a driver license, a state issued identification (ID) card, or a passport; or

   b. A written request or authorization form with a notarized signature.

B. Verification of a Member's Personal Representative:

1. Telephone and in-person: A Personal Representative shall provide information to identify his or her relationship to the Member in question. Accepted documents include:

   a. Legal documents: Executed power of attorney, proof of guardianship, medical power of attorney, certified letter of conservatorship, executor of will, letters testamentary, or letters of administration, or if the Member is deceased and the Personal Representative is the next of kin or other family member, accepted documentation may be the Personal Representative's birth certificate and driver's license; or

   b. A valid written authorization signed by the Member (signature must either be notarized, or a copy of a government issued identification must accompany the authorization) or the court.

2. Written request made by a Personal Representative: A Personal Representative shall include legal documentation with his or her written request to verify that he or she is the parent, conservator, guardian, executor of a decedent's will, or has medical decision making-authority for the individual, along with a notarized signature, or government issued identification of the Personal Representative.

3. Documentation of the Personal Representative's known relationship shall be documented in FACETS™ and the documentation provided by the Personal Representative shall be saved in the Customer Service Department shared files.

4. CalOptima shall grant a Member's Personal Representative access to a Member's PHI, in accordance with the following CalOptima Policies HH.3001Δ: Member Access to Designated Record Set, HH.3009Δ: Access by Member's Personal Representative, and HH.3015Δ: Authorization for Release of Protected Health Information.

C. Verification of a Disclosure requested by a family member, relative, close friend of the Member, or any other person identified by the Member:

1. Member is available: If the Member is available on the telephone or in person, CalOptima staff shall obtain the Member's consent before disclosing the PHI, or based on the circumstances, if it is inferred that the Member was given the opportunity to object and did not object to the Disclosure. Documentation of the Disclosure is required as follows:

   a. CalOptima staff shall document that the Member was present and verbally agreed to the Disclosure; or

b. The circumstances that led the CalOptima staff to believe that the Member agreed to, or did not object to, the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

2. Member is not available: If there is an emergency, or if the Member is incapacitated, CalOptima staff may use their professional judgment to determine whether the Disclosure of PHI is in the best interest of the Member. Staff may only disclose the PHI that is relevant to the person's involvement in the Member's care and shall document the emergency that supported the Disclosure of PHI to the family member, relative, close friend of the Member, or any other person identified by the Member.

a. CalOptima staff shall adhere to applicable state and federal regulations regarding minimum necessary uses and Disclosures of PHI, as well as CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information.

D. Written Requests for PHI:

1. A written request for copies of PHI may be accepted as valid, provided all information on the request is complete and accurate based on CalOptima data, subject to the verification requirements above.

2. A written request for copies of a minor's PHI may be accepted if the request is accompanied with valid legal documentation verifying that the requestor is the minor's Personal Representative.

3. A request from a Member's Personal Representative shall include either the appropriate legal documentation or written authorization from the Member to release the PHI, (signature must either be notarized or a copy of a government issued identification must accompany the authorization), unless otherwise permitted, in accordance with the following CalOptima Policies HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations, and HH.3010Δ: Protected Health Information Disclosures Required by Law.

3. Deceased Member: The PHI of a deceased Member is subject to the federal HIPAA privacy provisions for as long as CalOptima maintains the PHI. A Personal Representative with legal authority to act on behalf of a deceased Member or their estate may request the Member's PHI.

4. CalOptima shall verify the legal authority of a public official or person acting on behalf of a public official through a review of:

a. Documentation, statements, or presentations that, upon initial review, meet the applicable requirements for a Disclosure of PHI;

b. Presentation of an agency identification badge, other official credentials, or other proof of government authority;

c. Other evidence or documentation from an agency which establishes that the person is acting on behalf of the public official, such as a contract for services, memorandum of understanding, or purchase order;

d. A written statement of legal authority under which the information is requested;

e. If a written statement is impracticable, an oral statement of such legal authority; or

f. A request that is made pursuant to a warrant, subpoena, order, or other legal process issued by a grand jury, or a judicial or administrative tribunal, that is presumed to constitute legal authority.

E. Avert Serious Threat to Health or Safety. The verification requirements are met if CalOptima staff acts on good faith belief in making a Disclosure as follows:

1. Consistent with applicable law and standards of ethical conduct, CalOptima staff may Disclose PHI if staff in good faith believes the Disclosure:

a. Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

b. Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

2. CalOptima staff shall document the circumstances regarding his or her good faith belief, including whether the belief is based on staff's actual knowledge or reliance on a credible representation by a person with apparent knowledge or authority.

IV. ATTACHMENTS

A. Authorization for Release of Protected Health Information (PHI)
B. Individual Instruction Sheet for CalOptima HIPAA Authorization for Release of Protected Health Information Form

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreement
D. CalOptima Policy HH.3001Δ: Member Access to Designated Record Set
E. CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls
F. CalOptima Policy HH.3009Δ: Access by Member's Personal Representative
G. CalOptima Policy HH.3010Δ: Protected Health Information Disclosures Required by Law
H. CalOptima Policy HH.3011Δ: Use and Disclosure for Treatment, Payment and Health Care Operations
I. CalOptima Policy HH.3015Δ: Authorization for Release of Protected Health Information
J. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
K. Title 45, Code of Federal Regulations (C.F.R), §164.514(h)
L. Title 45, Code of Federal Regulations (C.F.R), §164.510(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	04/01/2007	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	12/01/2011	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare
Revised	09/01/2014	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3003	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Retired	12/01/2016	MA.9205	Verification of Identity for Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3003Δ	Verification of Identity for Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorized/Personal Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by Member's Personal Representative.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Member	A beneficiary who is enrolled in a CalOptima Program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

1

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Fill out **ALL** sections of this form to allow CalOptima to release your protected health information (PHI) to another person or agency. This form is **ONLY** to release the information. It will not allow anyone to make health care decisions for you.

SECTION A: Member Information

Last Name: _____ First Name: _____

CIN: _____ Date of Birth: _____ *mm/dd/yyyy*

Address: _____
Street/Unit Number *City* *State* *Zip Code*

Best phone number to contact you: _____

Instructions: Mark X inside the box next to your selected option.

SECTION B: Information That Can Be Released

I allow CalOptima to release:

☐ Any and all of my PHI

☐ Only release the following: (list what you allow):

_____

_____

I allow the release of PHI about:
(Initial if any of the below boxes are checked)

☐ Mental health treatment Initial:_____
☐ Alcohol / drug treatment Initial:_____

NOTE: These details will not be released unless you approve first.

SECTION C: Purpose of Authorization

I am releasing this information for:

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (please specify.): _____

SECTION D: Person(s) or Agency Allowed to Get PHI

I allow CalOptima to release my PHI to the person or agency below. I know this authorization starts when I sign and return this form. The person getting the information must be 18 years of age or older.

Person /Agency's Name(s): _____

Relationship to Member: _____ Phone: _____

SECTION E: My Rights

- I may stop this authorization at any time by sending a **written** notice to: CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange, CA 92868.
- Notice to stop this authorization will not change how CalOptima used or released my PHI before getting my letter.
- The person or agency who gets my PHI from CalOptima may show it to others. In this case, my PHI may no longer be protected by HIPAA Privacy Rules.
- I do not have to fill out this form. Not filling out this form will not change my health care benefits or payment for my health care services.
- I have the right to look at or get a copy of my PHI that is being used or released by this authorization.
- I have the right to get a copy of this form.

SECTION F: End Date of Approval

This authorization for release of information to the named persons or agency will end on: _____ (specific date or event).

**** If an end date or event is not provided, the authorization will not be valid. ****

SECTION G: Signature

I understand that to process my request, a copy of valid government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be attached with my request form.

By signing below, I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

CalOptima reserves the right to request legal documentation (e.g., birth certificate, court order, etc.) from the parent/guardian signing on behalf of a dependent member.

Personal Representatives Only: What rights do you have to request health information?

Print Name: _____

- ☐ Conservator
- ☐ Executor of Will
- ☐ Administrator of Estate
- ☐ Medical Power of Attorney
- ☐ Other_____

NOTE: You must attach legal documentation to verify that you are the conservator, executor of a decedent's will, or have medical decision-making authority for the individual.

Please mail this form to CalOptima, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange CA 92868, or fax it to **1-714-338-3104**.

STOP

For CalOptima Use Only:

Staff Name: _____ How was identity verified? In person/Phone

Signature: Date verified:

INSTRUCTION SHEET FOR CALOPTIMA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION C: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under **"Other"** and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter ***"To appeal a claim determination"*** or something similar in that block.

SECTION D: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include:** ***"Dr. John Smith" or "Mary Doe (spouse)."*** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION F: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, ***"one year from my signature date."***

SECTION G: SIGNATURE

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

- Examples of legal documents:
  - **Power of Attorney for Health Care —** this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
  - **Legal Guardianship —** this is when the court appoints someone to care for another person.
  - **Conservatorship of the Person —** this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
  - **Executor of Estate —** this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.

Policy #:	HH.3005Δ
Title:	**Member Request for Accounting of Disclosures**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	~~12/07/17~~12/06/18
Last Revised Date:	~~12/07/17~~12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy defines the scope of a Member's right to ~~request~~receive an accounting of Disclosures ~~made by CalOptima~~ of the Member's Protected Health Information (PHI) ~~created,~~made by CalOptima, including disclosures to or ~~maintained, in a Designated Record Set (DRS)~~ by ~~CalOptima or~~ its Business Associates.

II. POLICY

A. Upon a Member's request, CalOptima shall provide an accounting of PHI Disclosures released for a time period not to exceed six (6) years.

1. Disclosures excluded from accounting include Disclosures:

   a. To carry out Treatment, Payment and Health Care Operations;

   b. To individuals of PHI about them;

   c. Incident to a Use or Disclosure otherwise permitted or required;

   d. Pursuant to an authorization;

   e. ~~For the facility's directory or to~~To persons involved in the individual's care or other notification purposes as provided in Title 45, CFR, §164.510;

   f. For national security or intelligence purposes;

   g. To correctional institutions or law enforcement officials;

   h. As part of a limited data set; or

   i. That occurred prior to the compliance date for CalOptima.

j. For the facility's directory as provided in Title 45, CFR, §164.510 with respect to the Program of All-Inclusive Care for the Elderly (PACE) only.

B. The Office of Compliance shall track all other Disclosures of PHI not mentioned in Section II.A., in accordance with CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

C. Disclosure of PHI is not limited to hard-copy information and may include any information Disclosed by other means, such as verbally, electronic data release, or by facsimile.

D. CalOptima shall temporarily suspend a Member's right to receive an accounting of Disclosures pursuant to a request from a health oversight agency, or law enforcement official if:

1. CalOptima receives a written statement from such agency or official that an accounting to the Member would be reasonably likely to impede the agency's activities, and specifying the time for which such a suspension is required; or

2. A health oversight agency, or law enforcement official, provides a verbal statement to CalOptima, in which case CalOptima shall:

a. Document the statement, including the identity of the agency, or official, making the statement;

b. Temporarily suspend the Member's right to an accounting of Disclosures subject to the statement; and

c. Limit the temporary suspension to no longer than thirty (30) calendar days from the date of the oral statement, unless CalOptima receives a written request for suspension.

III. PROCEDURE

A. A Member may request an accounting of Disclosures of his or her PHI that CalOptima released, in the six (6) years prior to the date of the request (or lesser time, if requested), by submitting a Request for an Accounting of Disclosures Form to the Customer Service Department.

B. The Customer Service Department shall:

1. Provide the Member with a Request for an Accounting of Disclosures Form by U.S. mail, or in person at the CalOptima office; and

2. Assist the Member in completing the form, if necessary.

C. CalOptima's Customer Service Department shall forward all requests to the Privacy Officer, or Designee, who shall process the request.

D. CalOptima shall review a Member's request for an accounting of Disclosure from Members enrolled in a Health Network in coordination with the Health Network, or other Business Associate, as appropriate.

E. ~~A~~CalOptima must provide the Member with a ~~-~~written ~~account~~accounting of the Disclosures ~~shall~~ that meets the following requirements:

~~E.~~ Except as otherwise provided in Sections II. A.1 or II.D of this Policy, the accounting must include~~:~~

1. Disclosures of PHI that occurred during the six (6) years, or shorter time period as designated on the Member's request, prior to the date of the request for an accounting ~~specifying:~~, including Disclosures to or by CalOptima's Business Associates.

2. Except as otherwise provided in Section III.F of this Policy, the accounting must include for each Disclosure:

   a. The date of the Disclosure;

   b. The name of the entity, or person, who received the PHI, and if known, the address of such entity or person;

   c. A brief description of the PHI d~~D~~isclosed; and

   d. A brief statement of the purpose of the Disclosure that reasonably informs the individual of the basis for the Disclosure, or in lieu of such statement, a copy of a written request for a Disclosure.

F. ~~F.~~ If~~-~~, during the period covered by the accounting, CalOptima has made multiple ~~requests were made by~~Disclosures of PHI to the same ~~individual~~person or entity~~, CalOptima shall~~ for a single purpose under 45 CFR §§ 164.502 (a)(2)(ii) or 164.512, the accounting with respect to such multiple Disclosures, may provide ~~the~~:

1. The information required by Section III.E. for the first Disclosure ~~and the~~during the accounting period requested by the Member;

2. The frequency, periodicity, or number of Disclosures made during the accounting period requested by the Member; and ~~the~~

3. The date of the last such Disclosure during the accounting period requested by the Member.

G. The Office of Compliance shall act on the Member's request~~, and:~~ as follows:

1. Provide the Member with the ~~PHI~~ accounting within sixty (60) calendar days after the ~~date~~receipt of the ~~-~~request; or

2. If ~~the PHI~~ CalOptima is unable to provide the accounting ~~will not be prepared~~ within the sixty (60) calendar days, ~~communicate to the Member:~~extend the time by no more than thirty (30) calendar days.

a. For an extension, the Office of Compliance shall, within the sixty (60) calendar days after the receipt of the request, provide the member with a written statement of:

~~a.~~i. The reasons for the delay (i.e., why the PHI accounting will not be prepared within sixty (60) calendar days~~;~~) and

~~b.~~ii. The date ~~in~~by which the ~~PHI~~ accounting will be ~~prepared; and~~provided;

~~c.~~b. ~~Complete~~The Office of Compliance shall complete the request within ~~an additional thirty (30) calendar days after~~ the ~~expiration~~extended time period. CalOptima may have only one extension of the ~~initial sixty (60) calendar days.~~time for action on a request for an accounting.

H. Documentation

1. The Office of Compliance shall document the request in the Office of Compliance tracking database that shall include, but not be limited to:

   a. Date of request;

   b. Name of person who processed the request; and

   c. Date the accounting was released to Member.

2. The Office of Compliance shall maintain a copy of the PHI accounting provided to the Member for ten (10) years from the date the request is received.

I. CalOptima shall provide the Member with the first request for an accounting in any twelve (12) month period at no charge. CalOptima may charge the Member a reasonable, cost-based fee for each future request within the twelve (12) month period, provided that CalOptima informs the Member in advance of the fee, and offers the Member a chance to withdraw, or modify, the request to avoid, or reduce, the fee.

IV. ATTACHMENTS

A. Request for an Accounting of Disclosures Form
B. Response to Request for Accounting of Disclosures

V. REFERENCES

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 PACE Program Agreement
E. CalOptima Policy HH.3006Δ: Tracking Disclosures of Protected Health Information
F. CalOptima Privacy Program

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. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, 2002, Section 400-Medical Records Privacy Requirements
I. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 5-2017
J. Title 45, Code of Federal Regulations (CFR), ~~§§§~~ 164.502, 164.512, and 164.528

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Effective	06/01/2005	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	04/01/2007	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	01/01/2008	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	02/01/2008	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	07/01/2011	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	07/01/2011	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	01/01/2013	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	01/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	06/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	11/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	11/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	09/01/2015	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2015	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Term	Definition
~~Designated Record Set (DRS)~~	~~Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is:~~ ~~• The medical records and billing records about individuals maintained by or for a covered health care provider;~~ ~~• The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or~~ ~~• Used, in whole or in part, by or for the covered entity to make decisions about individuals.~~ ~~The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.~~
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
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.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care 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.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3005Δ
Title:	**Member Request for Accounting of Disclosures**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/03
Last Review Date:	12/06/18
Last Revised Date:	12/06/18

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy defines the scope of a Member's right to receive an accounting of Disclosures of the Member's Protected Health Information (PHI) made by CalOptima, including disclosures to or by its Business Associates.

II. POLICY

A. Upon a Member's request, CalOptima shall provide an accounting of PHI Disclosures released for a time period not to exceed six (6) years.

1. Disclosures excluded from accounting include Disclosures:

   a. To carry out Treatment, Payment and Health Care Operations;

   b. To individuals of PHI about them;

   c. Incident to a Use or Disclosure otherwise permitted or required;

   d. Pursuant to an authorization;

   e. To persons involved in the individual's care or other notification purposes as provided in Title 45, CFR, §164.510;

   f. For national security or intelligence purposes;

   g. To correctional institutions or law enforcement officials;

   h. As part of a limited data set; or

   i. That occurred prior to the compliance date for CalOptima.

j. For the facility's directory as provided in Title 45, CFR, §164.510 with respect to the Program of All-Inclusive Care for the Elderly (PACE) only.

B. The Office of Compliance shall track all other Disclosures of PHI not mentioned in Section II.A., in accordance with CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

C. Disclosure of PHI is not limited to hard-copy information and may include any information Disclosed by other means, such as verbally, electronic data release, or by facsimile.

D. CalOptima shall temporarily suspend a Member's right to receive an accounting of Disclosures pursuant to a request from a health oversight agency, or law enforcement official if:

1. CalOptima receives a written statement from such agency or official that an accounting to the Member would be reasonably likely to impede the agency's activities, and specifying the time for which such a suspension is required; or

2. A health oversight agency, or law enforcement official, provides a verbal statement to CalOptima, in which case CalOptima shall:

a. Document the statement, including the identity of the agency, or official, making the statement;

b. Temporarily suspend the Member's right to an accounting of Disclosures subject to the statement; and

c. Limit the temporary suspension to no longer than thirty (30) calendar days from the date of the oral statement, unless CalOptima receives a written request for suspension.

III. PROCEDURE

A. A Member may request an accounting of Disclosures of his or her PHI that CalOptima released, in the six (6) years prior to the date of the request (or lesser time, if requested), by submitting a Request for an Accounting of Disclosures Form to the Customer Service Department.

B. The Customer Service Department shall:

1. Provide the Member with a Request for an Accounting of Disclosures Form by U.S. mail, or in person at the CalOptima office; and

2. Assist the Member in completing the form, if necessary.

C. CalOptima's Customer Service Department shall forward all requests to the Privacy Officer, or Designee, who shall process the request.

D. CalOptima shall review a Member's request for an accounting of Disclosure from Members enrolled in a Health Network in coordination with the Health Network, or other Business Associate, as appropriate.

E. CalOptima must provide the Member with a written accounting of the Disclosures that meets the following requirements:

1. Except as otherwise provided in Sections II. A.1 or II.D of this Policy, the accounting must include Disclosures of PHI that occurred during the six (6) years, or shorter time period as designated on the Member's request, prior to the date of the request for an accounting, including Disclosures to or by CalOptima's Business Associates.

2. Except as otherwise provided in Section III.F of this Policy, the accounting must include for each Disclosure:

   a. The date of the Disclosure;

   b. The name of the entity, or person, who received the PHI, and if known, the address of such entity or person;

   c. A brief description of the PHI disclosed; and

   d. A brief statement of the purpose of the Disclosure that reasonably informs the individual of the basis for the Disclosure, or in lieu of such statement, a copy of a written request for a Disclosure.

F. If, during the period covered by the accounting, CalOptima has made multiple Disclosures of PHI to the same person or entity for a single purpose under 45 CFR §§ 164.502 (a)(2)(ii) or 164.512, the accounting with respect to such multiple Disclosures, may provide:

1. The information required by Section III.E. for the first Disclosure during the accounting period requested by the Member;

2. The frequency, periodicity, or number of Disclosures made during the accounting period requested by the Member; and

3. The date of the last such Disclosure during the accounting period requested by the Member.

G. The Office of Compliance shall act on the Member's request as follows:

1. Provide the Member with the accounting within sixty (60) calendar days after the receipt of the request; or

2. If CalOptima is unable to provide the accounting within the sixty (60) calendar days, extend the time by no more than thirty (30) calendar days.

   a. For an extension, the Office of Compliance shall, within the sixty (60) calendar days after the receipt of the request, provide the member with a written statement of:

      i. The reasons for the delay (i.e., why the PHI accounting will not be prepared within sixty (60) calendar days) and

      ii. The date by which the accounting will be provided;

b. The Office of Compliance shall complete the request within the extended time period. CalOptima may have only one extension of the time for action on a request for an accounting.

H. Documentation

1. The Office of Compliance shall document the request in the Office of Compliance tracking database that shall include, but not be limited to:

   a. Date of request;

   b. Name of person who processed the request; and

   c. Date the accounting was released to Member.

2. The Office of Compliance shall maintain a copy of the PHI accounting provided to the Member for ten (10) years from the date the request is received.

I. CalOptima shall provide the Member with the first request for an accounting in any twelve (12) month period at no charge. CalOptima may charge the Member a reasonable, cost-based fee for each future request within the twelve (12) month period, provided that CalOptima informs the Member in advance of the fee, and offers the Member a chance to withdraw, or modify, the request to avoid, or reduce, the fee.

IV. ATTACHMENTS

A. Request for an Accounting of Disclosures Form
B. Response to Request for Accounting of Disclosures

V. REFERENCES

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 PACE Program Agreement
E. CalOptima Policy HH.3006Δ: Tracking Disclosures of Protected Health Information
F. CalOptima Privacy Program
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. Guide to Medical Privacy and HIPAA, Thompson Publishing Group, 2002, Section 400-Medical Records Privacy Requirements
I. NCQA Standard MED5 Privacy and Confidentiality: Element A: Factor 5-2017
J. Title 45, Code of Federal Regulations (CFR), §§ 164.502, 164.512, and 164.528

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Effective	06/01/2005	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	04/01/2007	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	01/01/2008	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	02/01/2008	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	07/01/2011	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	07/01/2011	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	01/01/2013	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	01/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal OneCare
Revised	06/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	11/01/2014	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	11/01/2014	MA.9209	Member Request for Accounting of Disclosures	OneCare
Revised	09/01/2015	HH.3005	Member Request for an Accounting of Disclosures	Medi-Cal
Revised	09/01/2015	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9209	Member Request for Accounting of Disclosures	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/06/2018	HH.3005Δ	Member Request for Accounting of Disclosures	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.

Term	Definition
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance audits, health insurance underwriting, premium rating and other activities related to a contact and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
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.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Member	An enrollee-beneficiary of a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care 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.

Term	Definition
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Request for an Accounting of Disclosures Form

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Phone Number: _____

I would like a report of how my Protected Health Information (PHI) was disclosed by CalOptima, as required by law. I understand that CalOptima does not have to tell me about the following types of disclosures:

1. Disclosures for purposes of Treatment, Payment, and Health Care Operations.
2. Disclosures to me or authorized by me to another person(s).
3. Disclosures to persons involved in my care.
4. Disclosures made prior to April 14, 2003.

I also understand that my right to a report of some, or all disclosures, may be suspended in some instances.

I understand that CalOptima must give me the report of disclosures within 60 days of my request, or give notice to me that an extra 30 days (or less) is needed to prepare it.

I understand I am allowed 1 free report of disclosures every 12-months. I may be charged a fee if I ask for more than 1 report within the same 12-months.

Please note, this is not a request for Access to Protected Health Information (PHI). You will not get records such as Medical Claims or Pharmacy Claims by using this form. If you would like these type of records, please fill out the Individual Request for Access to Protected Health Information in the Designated Record Set form.

To learn more about your privacy rights, please visit our website at www.caloptima.org or call CalOptima's Customer Service Department toll-free at **1-888-587-8088**. Members with hearing or speech impairments can call our TDD/TTY line at **1-800-735-2929**. We have staff who can speak your language.

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I would like a record of disclosures that covers the following time period:

From:_____To: _____
Note: The time period may not be longer than six (6) years, and may not include dates before April 14, 2003.

Delivery method requested (select one):

☐ "Personal" pick-up at CalOptima (ID required at the time of pick-up)

☐ Mail:

Address/Unit _____ City _____ State _____ Zip _____

☐ Electronically, sent through a secure e-mail to: _____

Member Signature:_____ Date:_____

If Personal Representative, please complete the section below and provide documentation:

Print Name:_____Relationship to Member: _____

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[date]

[name]
[address] [city],
CA [zip]

Re: Request for Accounting of Disclosures

Dear Mr./Ms. [insert last name]:

We received your request for an accounting of disclosures of your Protected Health Information (PHI) on [date] for [date range]. [Our records show the following PHI disclosures have been made:] Our records show that your PHI was not disclosed for purposes other than the ones listed below, which describes the information that health care organizations are not required to release under the Health Insurance Portability and Accountability Act (HIPAA) regulation.

CalOptima is not required to provide you with an accounting of the following types of disclosures:

1. Disclosures for purposes of Treatment, Payment, and Health Care Operations.
2. Disclosures to me or authorized by me to another person(s).
3. Disclosures to persons involved in my care.
4. Disclosures made prior to April 14, 2003.

A copy of your Request for an Accounting of Disclosures Form is enclosed.

For more information about your privacy rights, please visit our website at www.caloptima.org or call CalOptima's Customer Service Department toll-free at **1-888-587-8088**. Members with hearing or speech impairments can call our TDD line at **1-800-735-2929.** We have staff who can speak your language.

Sincerely,

Encl.: Accounting of Disclosures Form

Policy #:	HH.3011Δ
Title:	**Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader
Effective Date:	04/01/03
Last Review Date:	~~12/07/17~~12/06/18
Last Revised Date:	~~12/07/17~~12/06/18

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy describes the requirements for the Use and Disclosure of Member ~~PHI~~Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

II. POLICY

A. CalOptima shall maintain the privacy of PHI in compliance with all federal and state laws when Using, or Disclosing, PHI for Treatment, Payment, and Health Care Operations, including applying the Minimum Necessary standard, when applicable.

B. Unless otherwise prohibited by other state or federal law, CalOptima may Use or Disclose PHI pertaining to a Member to perform functions, activities, or services for the purposes directly related to the administration of CalOptima programs.

C. CalOptima may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment, or Health Care Operations in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws to the extent that they are more protective of the Member's privacy.

D. Uses and Disclosures pursuant to a valid Member Authorization do not need to be tracked pursuant to CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

III. PROCEDURE

A. CalOptima may Use and Disclose PHI for its own Treatment purposes and may Disclose PHI for the Treatment purposes of a health care provider:

1. Treatment

a. Activities undertaken by designated staff on behalf of a Member that includes:

i. Direct and indirect provision of health care;

ii. Coordination and management of health care and related services;

iii. Referral to and consultation between health care Providers; and

iv. Coordination with third parties for services related to the management of the Member's health care benefits.

b. Examples of Treatment activities include, but are not limited to:

i. Disclosing a Member's PHI to facilitate Long Term Care (LTC) placement;

ii. Referral for home health care, physical therapy, obtaining Durable Medical Equipment (DME) or medical supplies; and

iii. Providing medical information when referring the Member for consultations with other Providers.

c. CalOptima may only Use PHI regarding mental health treatment for its own Treatment purposes.

2. Health Care Operations

a. CalOptima may Use and Disclose PHI for its own Health Care Operations. CalOptima may only Disclose PHI to another Covered Entity for the Health Care Operations of the other Covered Entity if:

i. Each party has or had a relationship with the Member who is the subject of the PHI being requested;

ii. The PHI pertains to such relationship;

iii. The Disclosure is for the following limited purposes:

a) Quality assessment and improvement activities;

b) Patient safety activities;

c) Population-based activities;

d) Credentialing and peer review;

e) Evaluations of health care performance training programs; and

f) Health care fraud and abuse detection and compliance as described in Title 45, Code of Federal Regulations, Section 164.506(c)(4) and where consistent with the administration of the Medi-Cal program.

b. The Minimum Necessary Rule applies to Uses and Disclosures for Health Care Operations.

3. Payment

a. CalOptima may Use and Disclose PHI for its own Payment activities and may Disclose PHI to another Covered Entity, or health care provider, for the payment activities of the entity that receives the information for CalOptima health care programs. The Minimum Necessary Rule applies to Uses and Discloses for Payment activities:

i. Determination of eligibility and to fulfill responsibility for coverage and provision of health benefits under agency programs;

ii. Reimbursement for provision of health care services and coordination of benefits with other health coverage;

iii. Risk adjustments based on Member health status and demographics, billing, claims management, and collection activities;

iv. Review of health care services regarding Medical Necessity, coverage under a health plan and appropriateness of care or justification of charges;

v. Utilization review activities including precertification, preauthorization, and concurrent and retrospective review of services;

vi. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums, or reimbursement:

a) Name and address;

b) Date of birth;

c) Social Security Number;

d) Payment History;

e) Account number; or

f) Name and address of CalOptima.

B. With respect to PHI regarding mental health treatment that is protected by Section 5328 of the Welfare & Institutions Code, CalOptima may Disclose such information and records as follows:

1. Communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the Member, his or her guardian or conservator, shall be obtained before information or records may be disclosed by a professional person employed by CalOptima to a professional person not employed by CalOptima who does not have the medical or psychological responsibility for the patient's care.

2. To the extent necessary for a Member to make a claim, or for a claim to be made on behalf of a Member for aid, insurance, or medical assistance to which he or she may be entitled.

3. To CalOptima's business associate or for Health Care Operations purpose, in accordance with Parts 160 and 164 of Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

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 PACE Program Agreement
E. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
F. CalOptima Policy HH.3019Δ: De-identification of Protected Health Information
G. CalOptima Privacy Program
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Title 42 Code of Federal Regulations, §431.00 et seq.
J. Title 45, Code of Federal Regulations, §§164.501, 164.502(b), and 164.506
K. Title 22, California Code of Regulations, §51009
L. Welfare and Institutions Code, ~~§§§~~5328 and 14100.2 (a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Effective	04/01/2003	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Effective	06/01/2005	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Effective	06/01/2005	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	04/01/2007	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/2007	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	01/01/2008	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	02/01/2008	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Revised	02/01/2008	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare
Revised	01/01/2010	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	12/01/2012	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	04/01/2013	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Revised	04/01/~~14~~2014	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Revised	09/01/2014	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
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Revised	09/01/2015	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3011Δ	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Retired	12/01/2016	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3011Δ	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3011Δ	Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code section 14100.2.
~~Authorized/~~Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Covered Service:	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract One Care Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the three-way agreement with the Department of Health Care Services and Centers for Medicare & Medicaid Services (CMS). PACE: Those items and services provided by CalOptima under the provisions of Welfare & Institutions Code section 14132 except those services specifically excluded under the contract with the Department of Health Care Services.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services
De-identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.

Term	Definition
Durable Medical Equipment (DME)	Walkers, wheelchairs, canes, crutches, helmets and other equipment that could be used by one (1) person and used again by another person (i.e., not single use equipment).
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
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.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
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.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, Physician Medical Group, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #: HH.3011Δ
Title: **Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations**
Department: Office of Compliance
Section: Privacy

CEO Approval: Michael Schrader _____

Effective Date: 04/01/03
Last Review Date: 12/06/18
Last Revised Date: 12/06/18

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

I. PURPOSE

This policy describes the requirements for the Use and Disclosure of Member Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

II. POLICY

A. CalOptima shall maintain the privacy of PHI in compliance with all federal and state laws when Using, or Disclosing, PHI for Treatment, Payment, and Health Care Operations, including applying the Minimum Necessary standard, when applicable.

B. Unless otherwise prohibited by other state or federal law, CalOptima may Use or Disclose PHI pertaining to a Member to perform functions, activities, or services for the purposes directly related to the administration of CalOptima programs.

C. CalOptima may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment, or Health Care Operations in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws to the extent that they are more protective of the Member's privacy.

D. Uses and Disclosures pursuant to a valid Member Authorization do not need to be tracked pursuant to CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information.

III. PROCEDURE

A. CalOptima may Use and Disclose PHI for its own Treatment purposes and may Disclose PHI for the Treatment purposes of a health care provider:

1. Treatment

a. Activities undertaken by designated staff on behalf of a Member that includes:

i. Direct and indirect provision of health care;

ii. Coordination and management of health care and related services;

iii. Referral to and consultation between health care Providers; and

iv. Coordination with third parties for services related to the management of the Member's health care benefits.

b. Examples of Treatment activities include, but are not limited to:

i. Disclosing a Member's PHI to facilitate Long Term Care (LTC) placement;

ii. Referral for home health care, physical therapy, obtaining Durable Medical Equipment (DME) or medical supplies; and

iii. Providing medical information when referring the Member for consultations with other Providers.

c. CalOptima may only Use PHI regarding mental health treatment for its own Treatment purposes.

2. Health Care Operations

a. CalOptima may Use and Disclose PHI for its own Health Care Operations. CalOptima may only Disclose PHI to another Covered Entity for the Health Care Operations of the other Covered Entity if:

i. Each party has or had a relationship with the Member who is the subject of the PHI being requested;

ii. The PHI pertains to such relationship;

iii. The Disclosure is for the following limited purposes:

a) Quality assessment and improvement activities;

b) Patient safety activities;

c) Population-based activities;

d) Credentialing and peer review;

e) Evaluations of health care performance training programs; and

f) Health care fraud and abuse detection and compliance as described in Title 45, Code of Federal Regulations, Section 164.506(c)(4) and where consistent with the administration of the Medi-Cal program.

b. The Minimum Necessary Rule applies to Uses and Disclosures for Health Care Operations.

3. Payment

   a. CalOptima may Use and Disclose PHI for its own Payment activities and may Disclose PHI to another Covered Entity, or health care provider, for the payment activities of the entity that receives the information for CalOptima health care programs. The Minimum Necessary Rule applies to Uses and Discloses for Payment activities:

      i. Determination of eligibility and to fulfill responsibility for coverage and provision of health benefits under agency programs;

      ii. Reimbursement for provision of health care services and coordination of benefits with other health coverage;

      iii. Risk adjustments based on Member health status and demographics, billing, claims management, and collection activities;

      iv. Review of health care services regarding Medical Necessity, coverage under a health plan and appropriateness of care or justification of charges;

      v. Utilization review activities including precertification, preauthorization, and concurrent and retrospective review of services;

      vi. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums, or reimbursement:

         a) Name and address;

         b) Date of birth;

         c) Social Security Number;

         d) Payment History;

         e) Account number; or

         f) Name and address of CalOptima.

B. With respect to PHI regarding mental health treatment that is protected by Section 5328 of the Welfare & Institutions Code, CalOptima may Disclose such information and records as follows:

   1. Communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the Member, his or her guardian or conservator, shall be obtained before information or records may be disclosed by a professional person employed by CalOptima to a professional person not employed by CalOptima who does not have the medical or psychological responsibility for the patient's care.

   2. To the extent necessary for a Member to make a claim, or for a claim to be made on behalf of a Member for aid, insurance, or medical assistance to which he or she may be entitled.

3. To CalOptima's business associate or for Health Care Operations purpose, in accordance with Parts 160 and 164 of Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

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 PACE Program Agreement
E. CalOptima Policy HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
F. CalOptima Policy HH.3019Δ: De-identification of Protected Health Information
G. CalOptima Privacy Program
H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. Title 42 Code of Federal Regulations, §431.00 et seq.
J. Title 45, Code of Federal Regulations, §§164.501, 164.502(b), and 164.506
K. Title 22, California Code of Regulations, §51009
L. Welfare and Institutions Code, §§5328 and 14100.2 (a)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3011	Use and Disclosure for Treatment, Payment, and Health Care Operations	Medi-Cal
Effective	04/01/2003	HH.3017	Use or Disclosure of Protected Health Information for Research	Medi-Cal
Effective	06/01/2005	MA.9214	Use and Disclosure for Treatment, Payment, and Health Care Operations	OneCare
Effective	06/01/2005	MA.9215	Use or Disclosure of Protected Health Information for Research	OneCare

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Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.

Term	Definition
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Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development activities related to compliance with the privacy rule.
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.
Limited Data Set	Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
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.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, Physician Medical Group, or other person or institution that furnishes Covered Services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy #:	HH.3020Δ
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/07
Last Review Date:	~~12/07/17~~12/06/18
Last Revised Date:	~~12/07/17~~12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy describes CalOptima's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/Personal Information (PHI/PI) and/or other unauthorized access, Use, or Disclosure of PHI/PI to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima shall report Security Incidents, Breaches of Unsecured PHI/PI, or other unauthorized access, Use or Disclosure of PHI/PI to regulators, as required by its regulatory contracts and applicable state and federal laws.

B. CalOptima Employees shall immediately report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to the CalOptima Privacy Officer, or Designee, in accordance with this policy.

C. Business Associates shall notify CalOptima of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI. Business Associates shall submit a written report to CalOptima of a suspected, or known, Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use or Disclosure of PHI/PI, in accordance with this policy.

D. CalOptima shall investigate such a Security Incident, Breach of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI and provide a written report of the investigation to DHCS in accordance with this policy.

E. CalOptima shall notify individual Members whose Unsecured PHI/PI has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima, which compromises the security or privacy of the PHI.

F. CalOptima shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PI in accordance with CalOptima policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima management, at its discretion, shall issue corrective action to employees and persons in CalOptima's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI in accordance with the HIPAA Violation Guidelines Matrix. CalOptima shall document any corrective actions that are applied.

~~G.~~H. Business Associates shall comply with CalOptima Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/PI or other unauthorized access, Use, or Disclosure of PHI/PI involves DHCS and/or CalOptima PHI/PI.

III. PROCEDURE

A. Discovery

1. CalOptima Employees, Health Networks, with the exception of ~~a HMO~~an HMO that satisfies the requirements of Section III.B.3. of this Policy, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI immediately after discovery to the CalOptima Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of Reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI, or PI;

      ii. Posting PHI or PI on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted;

      v. Downloading EPHI to a portable device in violation of CalOptima's policies (e.g., without expressed authority and required safeguards (encryption));

      vi. Faxes or emails that contain CalOptima PHI are misdirected to an unintended third party due to the use of incorrect fax numbers or emails; and

      vii. Theft of paper records with CalOptima PHI from an Employee's vehicle.

B. The CalOptima Privacy Officer~~,~~ or Designee~~,~~ shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. EPHI: The CalOptima Privacy Officer or Designee shall notify DHCS immediately after the discovery, in accordance with this policy, as applicable.

b. PHI in non-electronic form: The CalOptima Privacy Officer~~,~~ or Designee~~,~~ shall notify DHCS within twenty-four (24) hours after the initial discovery, in accordance with this policy.

c. The CalOptima Privacy Officer~~,~~ or Designee~~,~~ shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer by electronic mail or facsimile, and by telephone, as required and within twenty-four (24) hours.

2. Business Associates shall submit a written report directly to the CalOptima Privacy Officer~~,~~ or Designee~~,~~ within forty–eight (48) hours after the initial discovery. The written report shall contain the elements specified in the DHCS Privacy Incident Report Form. CalOptima shall investigate the incident and report directly to DHCS, in accordance with this policy.

3. If the Business Associate is an HMO that has a direct contract with Medi-Cal, the HMO shall report its discovery of a Breach directly to DHCS if it involves a CalOptima Member. The HMO shall simultaneously copy the report to the CalOptima Privacy Officer, or Designee, by electronic mail to Privacy@caloptima.org. The HMO Privacy Officer shall report the Breach as it pertains to CalOptima Members to DHCS using the guidelines in this policy.

4. Investigation and written report to DHCS:

a. The CalOptima Privacy Officer~~,~~ or Designee~~,~~ shall investigate the Security Incident, Breach of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI, and provide an interim written report of the investigation to the DHCS Privacy Officer, the DHCS Contract Manager, and the DHCS Information Security Officer within seventy-two (72) hours after the initial discovery.

b. Within ten (10) working days of the initial discovery, the CalOptima Privacy Officer~~,~~ or Designee~~,~~ shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

C. CalOptima shall complete the investigative report for DHCS by using the DHCS Privacy Incident Report Form.

D. CalOptima shall notify Members whose unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days after the date of discovery, which is the first day the breach is known by a Covered Entity, or would have been known by exercising reasonable diligence. CalOptima shall provide notification as specified below.

1. CalOptima shall write the notification in plain language and include, to the extent possible:

a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

b. A description of the types of Unsecured PHI/PI that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima shall provide notification in the following form:

a. CalOptima shall send written notification by first-class mail to the Member at the last known address ~~or~~. CalOptima may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail~~.~~ and such agreement has not been withdrawn. CalOptima may provide notification in one (1) or more mailings as information is available.

i. If the Member is deceased, CalOptima shall provide written notification by first-class mail to either the next of kin, or personal representative of the Member, if contact information is known.

ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima shall provide a substitute notice by a readily visible posting on the homepage of CalOptima's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media~~.~~ in the geographic areas where the Members affected by the Breach likely reside. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima deems a Breach incident to require urgency because of a possible imminent misuse of Unsecured PHI/PI, CalOptima may provide Breach notification to Members by telephone or other means, in addition to written notice.

E. The CalOptima Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /PI as follows:

1. For Breaches of Unsecured PHI/PI involving five hundred (500) or more Members, the CalOptima Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/PI involving less than five hundred (500) Members, the CalOptima Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

F. The CalOptima Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). CalOptima shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories.

G. For a Breach of Unsecured PHI/PI affecting more than five hundred (500) individuals, CalOptima shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

H. If a law enforcement official states to CalOptima that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima shall take the following action:

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima staff shall:

a. Document the statement, including the identity of the official making the statement; and

b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.H.1. of this Policy is submitted during that time.

IV. ATTACHMENTS

A. DHCS Privacy Incident Report Form
B. HIPAA Violation Guidelines Matrix

V. REFERENCES

A. CalOptima Business Associates Agreement
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Privacy Program

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. MMCD All Plan Letter 06001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
I. MMCD All Plan Letter 06005: Protected Health Information (PHI) and Notification of Breaches
J. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
K. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
L. Title 45, Code of Federal Regulations §164.400 et seq.
M. Title 45, Code of Federal Regulations §164.502
N. Title 45, Code of Federal Regulations §164.514
O. Title 45, Code of Federal Regulations §164.530
~~O.~~P. Title 42 United State Code (U.S.C) §17932(h)
~~P.~~Q. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

VI. REGULATORY AGENCY APPROVALS

A. 07/22/13: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3013	Mitigation	Medi-Cal
Effective	06/01/2005	MA.9217	Mitigation	OneCare
Revised	04/01/2007	HH.3013	Mitigation	Medi-Cal
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Effective	08/01/2007	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	02/01/2008	MA.9217	Mitigation	OneCare
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	11/01/2011	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	MA.9217	Mitigation	OneCare
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2013	HH.3013	Mitigation	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	MA.9217	Mitigation	OneCare
Revised	06/01/2014	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9217	Mitigation	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3013	Mitigation	Medi-Cal
Retired	12/01/2016	MA.9217	Mitigation	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

Term	Definition
	A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
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. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
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.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Personally Identifiable Information	PII is ―any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured Protected Health Information/Personal Information (PHI/PI)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for CalOptima is under the direct control of CalOptima, whether or not they are paid by CalOptima.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

Policy #:	HH.3020Δ
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/07
Last Review Date:	12/06/18
Last Revised Date:	12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes CalOptima's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/Personal Information (PHI/PI) and/or other unauthorized access, Use, or Disclosure of PHI/PI to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima shall report Security Incidents, Breaches of Unsecured PHI/PI, or other unauthorized access, Use or Disclosure of PHI/PI to regulators, as required by its regulatory contracts and applicable state and federal laws.

B. CalOptima Employees shall immediately report any suspected or known Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to the CalOptima Privacy Officer, or Designee, in accordance with this policy.

C. Business Associates shall notify CalOptima of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI. Business Associates shall submit a written report to CalOptima of a suspected, or known, Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use or Disclosure of PHI/PI, in accordance with this policy.

D. CalOptima shall investigate such a Security Incident, Breach of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI and provide a written report of the investigation to DHCS in accordance with this policy.

E. CalOptima shall notify individual Members whose Unsecured PHI/PI has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima, which compromises the security or privacy of the PHI.

F. CalOptima shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PI in accordance with CalOptima policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima management, at its discretion, shall issue corrective action to employees and persons in CalOptima's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI in accordance with the HIPAA Violation Guidelines Matrix. CalOptima shall document any corrective actions that are applied.

H. Business Associates shall comply with CalOptima Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/PI or other unauthorized access, Use, or Disclosure of PHI/PI involves DHCS and/or CalOptima PHI/PI.

III. PROCEDURE

A. Discovery

1. CalOptima Employees, Health Networks, with the exception of an HMO that satisfies the requirements of Section III.B.3. of this Policy, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI immediately after discovery to the CalOptima Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of Reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI, or PI;

      ii. Posting PHI or PI on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted;

      v. Downloading EPHI to a portable device in violation of CalOptima's policies (e.g., without expressed authority and required safeguards (encryption));

      vi. Faxes or emails that contain CalOptima PHI are misdirected to an unintended third party due to the use of incorrect fax numbers or emails; and

      vii. Theft of paper records with CalOptima PHI from an Employee's vehicle.

B. The CalOptima Privacy Officer or Designee shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure of PHI/PI to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. EPHI: The CalOptima Privacy Officer or Designee shall notify DHCS immediately after the discovery, in accordance with this policy, as applicable.

b. PHI in non-electronic form: The CalOptima Privacy Officer or Designee shall notify DHCS within twenty-four (24) hours after the initial discovery, in accordance with this policy.

c. The CalOptima Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer by electronic mail or facsimile, and by telephone, as required and within twenty-four (24) hours.

2. Business Associates shall submit a written report directly to the CalOptima Privacy Officer or Designee within forty–eight (48) hours after the initial discovery. The written report shall contain the elements specified in the DHCS Privacy Incident Report Form. CalOptima shall investigate the incident and report directly to DHCS, in accordance with this policy.

3. If the Business Associate is an HMO that has a direct contract with Medi-Cal, the HMO shall report its discovery of a Breach directly to DHCS if it involves a CalOptima Member. The HMO shall simultaneously copy the report to the CalOptima Privacy Officer, or Designee, by electronic mail to Privacy@caloptima.org. The HMO Privacy Officer shall report the Breach as it pertains to CalOptima Members to DHCS using the guidelines in this policy.

4. Investigation and written report to DHCS:

a. The CalOptima Privacy Officer or Designee shall investigate the Security Incident, Breach of Unsecured PHI/PI, and/or other unauthorized access, Use, or Disclosure of PHI/PI, and provide an interim written report of the investigation to the DHCS Privacy Officer, the DHCS Contract Manager, and the DHCS Information Security Officer within seventy-two (72) hours after the initial discovery.

b. Within ten (10) working days of the initial discovery, the CalOptima Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

C. CalOptima shall complete the investigative report for DHCS by using the DHCS Privacy Incident Report Form.

D. CalOptima shall notify Members whose unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days after the date of discovery, which is the first day the breach is known by a Covered Entity, or would have been known by exercising reasonable diligence. CalOptima shall provide notification as specified below.

1. CalOptima shall write the notification in plain language and include, to the extent possible:

a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

b. A description of the types of Unsecured PHI/PI that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima shall provide notification in the following form:

a. CalOptima shall send written notification by first-class mail to the Member at the last known address. CalOptima may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail and such agreement has not been withdrawn. CalOptima may provide notification in one (1) or more mailings as information is available.

i. If the Member is deceased, CalOptima shall provide written notification by first-class mail to either the next of kin, or personal representative of the Member, if contact information is known.

ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima shall provide a substitute notice by a readily visible posting on the homepage of CalOptima's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media in the geographic areas where the Members affected by the Breach likely reside. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima deems a Breach incident to require urgency because of a possible imminent misuse of Unsecured PHI/PI, CalOptima may provide Breach notification to Members by telephone or other means, in addition to written notice.

E. The CalOptima Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /PI as follows:

1. For Breaches of Unsecured PHI/PI involving five hundred (500) or more Members, the CalOptima Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/PI involving less than five hundred (500) Members, the CalOptima Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

F. The CalOptima Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). CalOptima shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories.

G. For a Breach of Unsecured PHI/PI affecting more than five hundred (500) individuals, CalOptima shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

H. If a law enforcement official states to CalOptima that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima shall take the following action:

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima staff shall:

a. Document the statement, including the identity of the official making the statement; and

b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.H.1. of this Policy is submitted during that time.

IV. ATTACHMENTS

A. DHCS Privacy Incident Report Form
B. HIPAA Violation Guidelines Matrix

V. REFERENCES

A. CalOptima Business Associates Agreement
B. CalOptima Compliance Plan
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima PACE Program Agreement
F. CalOptima Privacy Program
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. MMCD All Plan Letter 06001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
I. MMCD All Plan Letter 06005: Protected Health Information (PHI) and Notification of Breaches
J. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
K. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
L. Title 45, Code of Federal Regulations §164.400 et seq.
M. Title 45, Code of Federal Regulations §164.502
N. Title 45, Code of Federal Regulations §164.514
O. Title 45, Code of Federal Regulations §164.530
P. Title 42 United State Code (U.S.C) §17932(h)
Q. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

VI. REGULATORY AGENCY APPROVALS

A. 07/22/13: Department of Health Care Services

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2003	HH.3013	Mitigation	Medi-Cal
Effective	06/01/2005	MA.9217	Mitigation	OneCare
Revised	04/01/2007	HH.3013	Mitigation	Medi-Cal
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Effective	08/01/2007	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	02/01/2008	MA.9217	Mitigation	OneCare
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	11/01/2011	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	HH.3013	Mitigation	Medi-Cal
Revised	12/01/2012	MA.9217	Mitigation	OneCare
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2013	HH.3013	Mitigation	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	MA.9217	Mitigation	OneCare
Revised	06/01/2014	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3013	Mitigation	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9217	Mitigation	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2016	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	HH.3013	Mitigation	Medi-Cal
Retired	12/01/2016	MA.9217	Mitigation	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9222	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3020Δ	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part. (iii) A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

Term	Definition
	A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
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. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
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.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima or its Business Associates.

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Personally Identifiable Information	PII is ―any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured Protected Health Information/Personal Information (PHI/PI)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for CalOptima is under the direct control of CalOptima, whether or not they are paid by CalOptima.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

PRIVACY INCIDENT REPORT (PIR)

The information reported in this form will be strictly confidential. The information reported in this form will be used to review your determination of whether a breach has occurred.

*☐ = Required items within 72 hours of discovery, to the extent known

† = US Health and Human Services (HHS) required information

1. SUMMARY OF PRIVACY INCIDENT *† (Please include location of the Privacy Incident, how the Privacy Incident occurred, and any information regarding the type of media and protected health information involved in the Privacy Incident.)

2. BASIC INFRMATION *†

DHCS Privacy Incident case number (this will be assigned after initial report):

Reporting entity's Privacy Incident case number (if applicable):

Date of most recent updates (today's date):

Reporting entity:	Type of Entity:	HIPAA Covered Entity?

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

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The type of contract the reporting entity has with DHCS?

Entity that caused Privacy Incident:

HIPAA Covered Entity?

Reporting entity's relationship with the entity that caused the Privacy Incident:

Date(s) of Privacy Incident: **Dates(s) of discovery:** **Date of notice to DHCS:**

Number of individuals affected by Privacy Incident:

What was the primary job function of the person(s) known, or reasonably believed, to have improperly sent, used, accessed, or disclosed PHI/PI (include employer/employee status, and any other pertinent information)?

What was the primary job function of the person(s) who viewed or (accidentally) obtained PHI/PI (include employer, employee status, other health plan member, and any other pertinent information)?

Additional basic information:

Was this incident a Violation of your Policies and Procedures?

If yes, please explain:

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

3. CONTACT INFORMATION *†

Reporting entity's contact's name:

Reporting entity's contact's e-mail:

Reporting entity's contact's telephone number:

Was this incident reported to any other entities/persons(s):

If the answer to the above questions is 'yes', then list the contact information of the entity/person the report was filed with:

4. PROTECTED HEALTH INFORMATION (PHI)/PERSONALLY IDENTIFIABLE (PI)*

Does the information disclosed in the Privacy Incident provide a reasonable basis to believe it can be used to identify an individual?

Does the information disclosed in the Privacy Incident relate to the past, present, or future physical or mental health, or condition of an individual?

Does the information involved in the Privacy Incident relate to the payment or provision of health care to an individual?

5. TYPE OF PRIVACY INCIDENT *†

- ☐ Improper Disposal
- ☐ Theft
- ☐ Loss
- ☐ Unauthorized Disclosure
- ☐ Mis-Sent
- ☐ Hacking/IT Incident
- ☐ Unauthorized Use/Access
- ☐ Unknown
- ☐ Other

If other, please explain:

6. TYPE OF PROTECTED INFORMATION INVOLVED *†

DEMOGRAPHIC INFORMATION

- ☐ First Name or Initial
- ☐ Last Name
- ☐ Address/Zip
- ☐ CIN or Medi-Cal #
- ☐ Date of Birth
- ☐ Social Security Number
- ☐ Driver's License
- ☐ Membership #
- ☐ Health Plan Name
- ☐ User Name/Email Address with Password
- ☐ Other

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

If other type of protected information, please explain:

FINANCIAL INFORMATION

☐ Credit Card / Bank Acct# ☐ Claims Information ☐ Other

If other, please explain:

CLINICAL INFORMATION

☐ Diagnosis / Condition ☐ Medications ☐ Psychotherapy notes

☐ Mental Health Data ☐ Lab Results ☐ Substance Use / Alcohol Data

☐ Other

If other, please explain:

Please list all the data elements originally obtained from DHCS:

Please list all the data elements originally obtained from or verified by the Social Security Administration:

7. LOCATION OF INFORMATION DISCLOSED IN PRIVACY INCIDENT *†

☐ Laptop ☐ Network Server ☐ Desktop Computer

☐ Portable Electronic Device ☐ Email ☐ Electronic Record

☐ Paper Data ☐ Smart Phone ☐ Hard Drive

☐ CD / DVD ☐ PDA ☐ Tape / DLT / DASD

☐ USB Thumb Drive ☐ Fax ☐ Other

If other, please explain: if network server please provide the name of the server and who owns it:

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

8. APPLICABLE SAFEGUARDS IN PLACE PRIOR TO PRIVACY INCIDENT *†

☐ Strong Authentication	☐ Packet Filtering	☐ Anti-Virus Software
☐ Secure Browser Sessions	☐ Biometrics	☐ Encrypted Wireless
☐ Physical Security	☐ Firewalls	☐ Logical Access Control
☐ Data Leak Protection	☐ Encrypted	☐ Intrusion Detection

Was staff involved in Privacy Incident trained in HIPAA information Security and Privacy within the past year?

Additional information regarding safeguards:

9. MALICIOUS CODE/MALWARE TYPE

☐ Worm	☐ Buffer Overflow	☐ Virus
☐ Trojan	☐ Denial of Service (DOS)	☐ Other

If other, please explain:

10. DATA AND RECOVERY *

Were any DHCS systems involved?

Was data encrypted per NIST standards?

Was data recovered?

If data was recovered, specify what, when, and who has it now:

If not recovered, explain (still missing/shredded/under investigation):

Discuss the impact of Privacy Incident (potential misuse of data, identity theft, etc.):

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

11. DHCS PROGRAM DATA

How many DHCS Program beneficiaries' PHI or PI were impacted by the Privacy Incident? *

Did this Privacy Incident involve a minor (<18 yrs.)?

Was PHI or PI in question utilized in the administration of the Medi-Cal Program?

12. SUPPLEMENTARY DESCRIPTION OF PRIVACY INCIDENT † (Please include any supplementary information regarding the Privacy Incident)

13. ACTIONS TAKEN IN RESPONSE TO PRIVACY INCIDENT †

Describe mitigation plan and status (if necessary attach separately):

Investigation status (i.e. completed, estimated completion date, etc.):

Status of member notification letter (if applicable):

Describe Corrective Action Plan (CAP) and status (attach CAP separately if needed):

Note: A CAP is implemented in an attempt to prevent this type of Privacy Incident from reoccurring.

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

Enter the CAP completion/implementation date (Or the date it is scheduled):

14. BREACH DEFINITIONS AND EXCEPTIONS

Did Privacy Incident fall under one of the three exclusions?

If an exclusion, please explain circumstances.

15. BREACH DETERMINATION †

Has your entity determined this to be a Federal Breach?

Has your entity determined this to be a State Breach?

An incident is presumed to be a breach. If you have evidence under 45 CFR 164.402(2)(1)(i),(ii),(iii),(iv), please provide the evidence and the HIPAA provision that applies to find that a breach does not exist below.

This may be submitted in a seperate document. If this is the case please enter "Attached" below.

16. BREACH REPORTING (if applicable) †

Date of Federal breach reporting to OCR (if applicable).

If you did not enter a date above, remember that it is your responsibility to report breaches as required by Federal regulation.

Date of State breach reporting to Attorney General's office (if applicable).

If you did not enter a date above, remember that it is your responsibility to report breaches as required by State Law.

Return completed form to: privacyofficer@dhcs.ca.gov or fax to: (916) 440-7680

HIPAA Violation Guidelines Matrix

Violations of Privacy or Security of Protected Health Information (PHI) Or Other Confidential Information

The HIPAA (Health Insurance Portability and Accountability Act) Violation Guidelines Matrix is intended to be used as a guide for selecting the appropriate level of corrective action for policy and/or regulatory violations. The Guidelines include specific examples of violations or breaches of HIPAA/Privacy regulations.

Therefore, the following are guidelines for potential corrective action for violations of HIPAA/Privacy regulations and related CalOptima policies. The offenses listed are not an exhaustive list of violations or possible corrective actions that may be taken. CalOptima may elect to follow the Guidelines, skip any of the steps, or immediately terminate an employee, as all CalOptima employees are at-will. Nothing in these guidelines modifies – or should be interpreted to modify – the at-will employment status of employees. As at-will employees, CalOptima employees are not guaranteed a right to corrective action prior to termination and can be terminated at any time, with or without cause, and with or without notice. (CalOptima Policy GA.8022: Performance and Behavior Standards).

CalOptima will evaluate the facts and circumstances of each incident on a case-by-case basis and will consider the severity and potential harm associated with each incident. The Office of Compliance and Human Resources will review all cases before corrective action is implemented. The Legal Affairs Office will review termination cases before implemented.

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
Level I	• Misdirected faxes, emails & mail. • Failure to log -off or lock a computer containing PHI when leaving the computer unattended. • Leaving paper PHI unattended in a publicly accessible area. • Dictating or discussing PHI in a non-secure area (lobby, hallway, cafeteria, and elevator). • Sending PHI from a CalOptima email account to an outside entity without using "send secure". • Storing files with PHI on a public network folder without a password.	• First Offense - Verbal Coaching/Coaching Memo • Second Offense - Documented Counseling Memo • Repeated Offenses – Further corrective action up to and including termination • Notify Privacy Officer of all incidents immediately • Repeat HIPAA and Information Security Online Training	**Mitigating Factors** • The recipient was a covered entity and attested to shredding/deleting/destroying the information. • The PHI was retrieved, deleted or made inaccessible **before it was viewed** (opened, read) by an unauthorized individual. • Employee self-reported incident after mistake occurred. • Employee has a legitimate business reason for transmitting/disclosing the PHI. • This was a first-time violation. **Aggravating Factors**

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
Level II	• Improper disposal of PHI. • Transmission of PHI/Confidential information to or from a personal email account without proper encryption, impacting fewer than 500 members. • For teleworkers, printing member PHI to a non-CalOptima issued printer. • Inappropriately sharing ID/password with others (e.g., co-workers or friends & family) or encouraging others to share ID/password. • Leaving laptops, cell phones, portable electronic devices unattended when traveling. • Failing to properly verify that an individual is authorized to manage the member's PHI on the phone before disclosing PHI.	• First Offense - Documented Counseling Memo/Final Written Warning • Second Offense - Termination, certain mitigating/aggravating factors may be considered for outcome of corrective action, including, but not limited to: 1. Documentation of training 2. Prior counseling(s)/corrective action • Notify Privacy Officer and Chief Information Officer	• The recipient of the PHI is unknown or is an individual who may have reason/cause to use the information in a malicious or harmful manner or for personal/financial gain. • The information disclosed/ accessed could not be retrieved/returned/shredded. This would include situations where PHI is sent via email and the email was opened. • The information accessed or disclosed included sensitive data (i.e. mental/behavioral health data, substance abuse, STD/HIV information) or financial data (HICN, SSN, bank account numbers, etc.). • The number of members impacted is more than 500. • The employee was deceptive or uncooperative during the investigation or regarding disclosure or access of PHI. • The employee has previously received training or corrective actions for a prior or similar violation. • The current misconduct found or acknowledged by the employee evidences multiple acts of wrongdoing or demonstrates a pattern of misconduct. • The violation occurred during the employee's resignation period. • There was no legitimate business reason for the employee to transmit and/or disclose the PHI.
Level III	• Requesting another coworker to inappropriately access and/or disclose PHI. • Intentionally accessing or allowing access to PHI without having a legitimate business reason and authorization. • Accessing member information such as a family member, friend, neighbor, coworker due to curiosity or concern. • Posting PHI to social media absent any aggravating factor. • Downloading/Uploading PHI/PII to external non-approved share site, website or external storage sites without	• Termination-no mitigation • Notify Privacy Officer and Chief Information Officer.	

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
	prior written authorization from IS and business leaders. • Intentionally or with gross negligence, downloads malware onto CalOptima's system that may result in a reported security breach incident. • Failure to report a breach, retaliating for reporting a breach, or hampering an investigation of a breach.		
Level IV	• Accessing or disclosing PHI or PII for financial or personal gain. • Malicious disclosure or malicious use of PHI. • Tampering with, modification of, and/or unauthorized destruction of PHI. • Falsifying documentation. • Posting PHI to social media in conjunction with any aggravating factor. • Acts that results in criminal or civil prosecution, where appropriate.	• Termination – no mitigation • Violation will be reported to licensing boards, law enforcement and/or third-party agencies, where appropriate or required. • Notify Privacy Officer and Chief Information Officer	

Policy #:	HH.4001Δ
Title:	**Audit & Oversight Committee**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	~~12/07/17~~12/06/18
Last Revised Date:	~~12/07/17~~12/06/18
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

~~*Board Approved Policy*~~

I. PURPOSE

This policy identifies the functions and responsibilities of the ~~Compliance~~Audit & Oversight Committee (AOC) responsible for oversight of CalOptima's internal departments and its First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. Oversight of delegated and internal operations is critical to CalOptima, as this process is mandated by federal, state, regulatory contracts, regulations, and accreditation standards, and is necessary to ensure sound fiscal practices, prevent Fraud, Waste, and Abuse, and the provision of quality health care to CalOptima Members.

III. PROCEDURE

A. Audit & Oversight Committee (AOC) members shall include the following CalOptima staff, serving either on a permanent, or interim, basis:

1. Executive Director, Operations;
2. Executive Director, Network Management;
3. Chief Financial Officer;
4. Chief Medical Officer;
5. Medical Director, Behavioral Health;
6. Executive Director, Compliance; and
7. Director, Pharmacy Management.

B. The ~~Director~~Directors of Audit & Oversight shall serve as the chair of the Audit & Oversight Committee (AOC).

C. Voting members may appoint a Designee, as appropriate. The Designee shall serve as a subject matter expert at the AOC.

D. Establishment of Quorum

1. A quorum for the committee is based on majority. A quorum is required for AOC to take action on any agenda item.

2. There must be at least four (4) members, or their Designee of the AOC present, in addition to the chair, to establish a quorum.

3. In the absence of quorum, the meeting may proceed; however, any issues requiring a vote shall be deferred until the next regular meeting, or subject to an electronic vote.

E. CalOptima's AOC shall conduct the following activities:

1. Oversee the monitoring, auditing, and reporting processes for internal departments and identified ~~First Tier, Downstream, and Related Entities (FDRs)~~FDRs including, but not limited to delegated Health Networks;

2. Provide oversight of internal departments and FDRs who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;

3. Recommend sanctions upon an ~~FDR,~~FDRs up to and including the revocation or termination of delegation if the delegated entity's performance is inadequate, in accordance with CalOptima Policy HH.2002Δ: Sanctions;

4. Assist CalOptima in ensuring ~~FDR~~FDRs and internal ~~department~~departments are in compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and any future programs in which CalOptima participates.

5. Establish clearly defined processes and criteria for the evaluation and categorization of internal departments, vendors, and delegated health care providers, as to the entity's qualification as an FDR and conduct such determinations on an ongoing basis.

6. Develop, or revise, reporting for internal ~~department(s)~~departments and FDRs including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to Corrective Action Plans (CAPs), in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, and present such proposals to the Compliance Committee for review and approval.

F. All activities of the AOC shall be privileged and not subject to disclosure, with the exception of aggregated reporting results.

G. AOC Responsibilities:

1. Oversight and Reporting

   a. Oversee the ~~pre-delegation/~~readiness assessment processes conducted by Audit & Oversight Department in conjunction with relevant operational departments;

      i. Review and approve findings or ~~pre-delegation/~~readiness assessment to evaluate ~~FDR~~an FDRs ability to perform delegated functions.

   b. Report quarterly findings and recommendations related to Audit & Oversight activities to the Compliance Committee for corrective/remedial action;

   c. Conduct focused oversight reviews deemed necessary by the AOC to ensure that any deficiencies reported during the oversight of the FDRs and/or internal departments have been fully addressed; and

   d. Report and make recommendations to the Compliance Committee on a regular, but no less than quarterly~~, basis~~. All AOC recommendations that potentially impact Members' access to covered services, or quality of care that requires prompt action, shall be referred immediately to CalOptima's Compliance Committee, as appropriate under the circumstances for review and action.

2. Audit & Oversight Work Plan

   a. In accordance with CalOptima ~~policy~~Policy HH.4003Δ: Annual Risk Assessment (Internal) and CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate), the Audit & Oversight Department will identify ~~FDRs~~ First Tier Entities (FTEs) and internal departments that pose the highest compliance risk and develop an annual Audit & Oversight work plan. Based upon a risk assessment that identifies the highest risk ~~FDR~~FTEs, which includes FTE's risk assessments, monitoring, and auditing of the Downstream Entities with which they contract, and internal departments ~~create~~, an annual Audit & Oversight work plan is created.

   b. Include activities identified in other Department Work Plans in the Audit & Oversight Work Plan.

   c. The annual risk assessments and Audit & Oversight Work Plan shall also be presented to the Compliance Committee for review and approval.

3. ~~Annual~~Audit and Oversight Report

   a. Prepare ~~an Annual Report~~a report, at least annually, of internal department and FDR oversight activities resulting from the Audit & Oversight Work Plan and other relevant ad hoc oversight activities including those related to risk assessments and/or arising from auditing activities (both internal and external).

   b. The ~~Annual Report~~report shall include recommendations related to changes and/or addition of oversight activities.

c. The ~~Annual Report~~report shall be presented to the Compliance Committee for review and approval.

4. AOC Meetings

a. The AOC shall meet at least monthly and may meet more frequently, as appropriate. The AOC chair, or any four (4) members of the AOC, may call a meeting of the AOC. Annually, AOC members shall receive a calendar request of meetings for the following calendar year.

b. The following, but not limited to, shall be distributed to all meeting attendees prior to the AOC meeting:

i. Meeting agenda;

ii. Final draft of previous AOC minutes for approval;

iii. Listing of open action items; and

iv. Presentation items.

c. Minutes of the AOC meeting shall be confidential.

d. Ad-hoc AOC meetings may be held at the discretion of the chairperson, as deemed appropriate.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

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 Contract for Health Care Services
E. CalOptima Health Network Service Agreement
F. CalOptima PACE Program Agreement
G. CalOptima Policy HH.2002Δ: Sanctions
H. CalOptima Policy HH.2005Δ: Corrective Action Plan
I. CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate)
J. CalOptima Policy HH.4003: Annual Risk Assessment (Internal)
K. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
B. 12/07/17: Regular Meeting of the CalOptima Board of Directors
C. 12/01/16: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	09/01/2015	HH.4001	Delegation Oversight Committee	Medi-Cal
Effective	09/01/2015	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9127	Delegation Oversight Committee	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.4001Δ	Audit & Oversight Committee	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit and Oversight Committee (AOC)	A subcommittee of the Compliance Committee co-chaired by the Director of Audit and Oversight to oversee CalOptima's delegated functions. The composition of the AOC includes representatives from CalOptima's operational departments.
Compliance Committee	Committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance; and Executive Director of Human Resources.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. ~~FDRs~~FTEs, including the Downstream Entities with which they contract, 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.
First Tier, Downstream, and Related Entities (FDR)	~~FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.~~First Tier, Downstream or Related Entity as separately defined herein.

Term	Definition
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.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. Section 1347.)
Health Network	The contracted health networks of CalOptima, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
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.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy #:	HH.4001Δ
Title:	**Audit & Oversight Committee**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	Michael Schrader _____
Effective Date:	09/01/15
Last Review Date:	12/06/18
Last Revised Date:	12/06/18

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☒ PACE

I. PURPOSE

This policy identifies the functions and responsibilities of the Audit & Oversight Committee (AOC) responsible for oversight of CalOptima's internal departments and its First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. Oversight of delegated and internal operations is critical to CalOptima, as this process is mandated by federal, state, regulatory contracts, regulations, and accreditation standards, and is necessary to ensure sound fiscal practices, prevent Fraud, Waste, and Abuse, and the provision of quality health care to CalOptima Members.

III. PROCEDURE

A. Audit & Oversight Committee (AOC) members shall include the following CalOptima staff, serving either on a permanent, or interim, basis:

1. Executive Director, Operations;
2. Executive Director, Network Management;
3. Chief Financial Officer;
4. Chief Medical Officer;
5. Medical Director, Behavioral Health;
6. Executive Director, Compliance; and
7. Director, Pharmacy Management.

B. The Directors of Audit & Oversight shall serve as the chair of the Audit & Oversight Committee (AOC).

C. Voting members may appoint a Designee, as appropriate. The Designee shall serve as a subject matter expert at the AOC.

D. Establishment of Quorum

1. A quorum for the committee is based on majority. A quorum is required for AOC to take action on any agenda item.

2. There must be at least four (4) members, or their Designee of the AOC present, in addition to the chair, to establish a quorum.

3. In the absence of quorum, the meeting may proceed; however, any issues requiring a vote shall be deferred until the next regular meeting, or subject to an electronic vote.

E. CalOptima's AOC shall conduct the following activities:

1. Oversee the monitoring, auditing, and reporting processes for internal departments and identified FDRs including, but not limited to delegated Health Networks;

2. Provide oversight of internal departments and FDRs who perform applicable core administrative functions and/or health care services for any of CalOptima's programs by evaluating performance measures and audit findings;

3. Recommend sanctions upon an FDRs up to and including the revocation or termination of delegation if the delegated entity's performance is inadequate, in accordance with CalOptima Policy HH.2002Δ: Sanctions;

4. Assist CalOptima in ensuring FDRs and internal departments are in compliance with accreditation, contractual, and regulatory requirements for administering all CalOptima programs including Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and any future programs in which CalOptima participates.

5. Establish clearly defined processes and criteria for the evaluation and categorization of internal departments, vendors, and delegated health care providers, as to the entity's qualification as an FDR and conduct such determinations on an ongoing basis.

6. Develop, or revise, reporting for internal departments and FDRs including, but not limited to, identifying the scope, frequency and nature of oversight monitoring and auditing, and recommendations related to Corrective Action Plans (CAPs), in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, and present such proposals to the Compliance Committee for review and approval.

F. All activities of the AOC shall be privileged and not subject to disclosure, with the exception of aggregated reporting results.

G. AOC Responsibilities:

1. Oversight and Reporting

a. Oversee the readiness assessment processes conducted by Audit & Oversight Department in conjunction with relevant operational departments;

   i. Review and approve findings or readiness assessment to evaluate an FDRs ability to perform delegated functions.

b. Report quarterly findings and recommendations related to Audit & Oversight activities to the Compliance Committee for corrective/remedial action;

c. Conduct focused oversight reviews deemed necessary by the AOC to ensure that any deficiencies reported during the oversight of the FDRs and/or internal departments have been fully addressed; and

d. Report and make recommendations to the Compliance Committee on a regular, but no less than quarterly. All AOC recommendations that potentially impact Members' access to covered services, or quality of care that requires prompt action, shall be referred immediately to CalOptima's Compliance Committee, as appropriate under the circumstances for review and action.

2. Audit & Oversight Work Plan

a. In accordance with CalOptima Policy HH.4003Δ: Annual Risk Assessment (Internal) and CalOptima Policy HH.2027Δ: Annual Risk Assessment (Delegate), the Audit & Oversight Department will identify First Tier Entities (FTEs) and internal departments that pose the highest compliance risk and develop an annual Audit & Oversight work plan. Based upon a risk assessment that identifies the highest risk FTEs, which includes FTE's risk assessments, monitoring, and auditing of the Downstream Entities with which they contract, and internal departments, an annual Audit & Oversight work plan is created.

b. Include activities identified in other Department Work Plans in the Audit & Oversight Work Plan.

c. The annual risk assessments and Audit & Oversight Work Plan shall also be presented to the Compliance Committee for review and approval.

3. Audit and Oversight Report

a. Prepare a report, at least annually, of internal department and FDR oversight activities resulting from the Audit & Oversight Work Plan and other relevant ad hoc oversight activities including those related to risk assessments and/or arising from auditing activities (both internal and external).

b. The report shall include recommendations related to changes and/or addition of oversight activities.

c. The report shall be presented to the Compliance Committee for review and approval.

4. AOC Meetings

a. The AOC shall meet at least monthly and may meet more frequently, as appropriate. The AOC chair, or any four (4) members of the AOC, may call a meeting of the AOC. Annually, AOC members shall receive a calendar request of meetings for the following calendar year.

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None to Date

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A. 12/06/18: Regular Meeting of the CalOptima Board of Directors
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1

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

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

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

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Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

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WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

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4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

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

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018: Rev. 6/7/2018
        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~ 6/7/2018: Continued to future Board meeting.

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

Implementation Plan Elements

Delivery Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Candidates for the open positions are as follows:
Family Representatives

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

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

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

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

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

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

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

~~*CBO/Advocate Representatives*~~

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

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

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

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

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

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

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

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Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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Background

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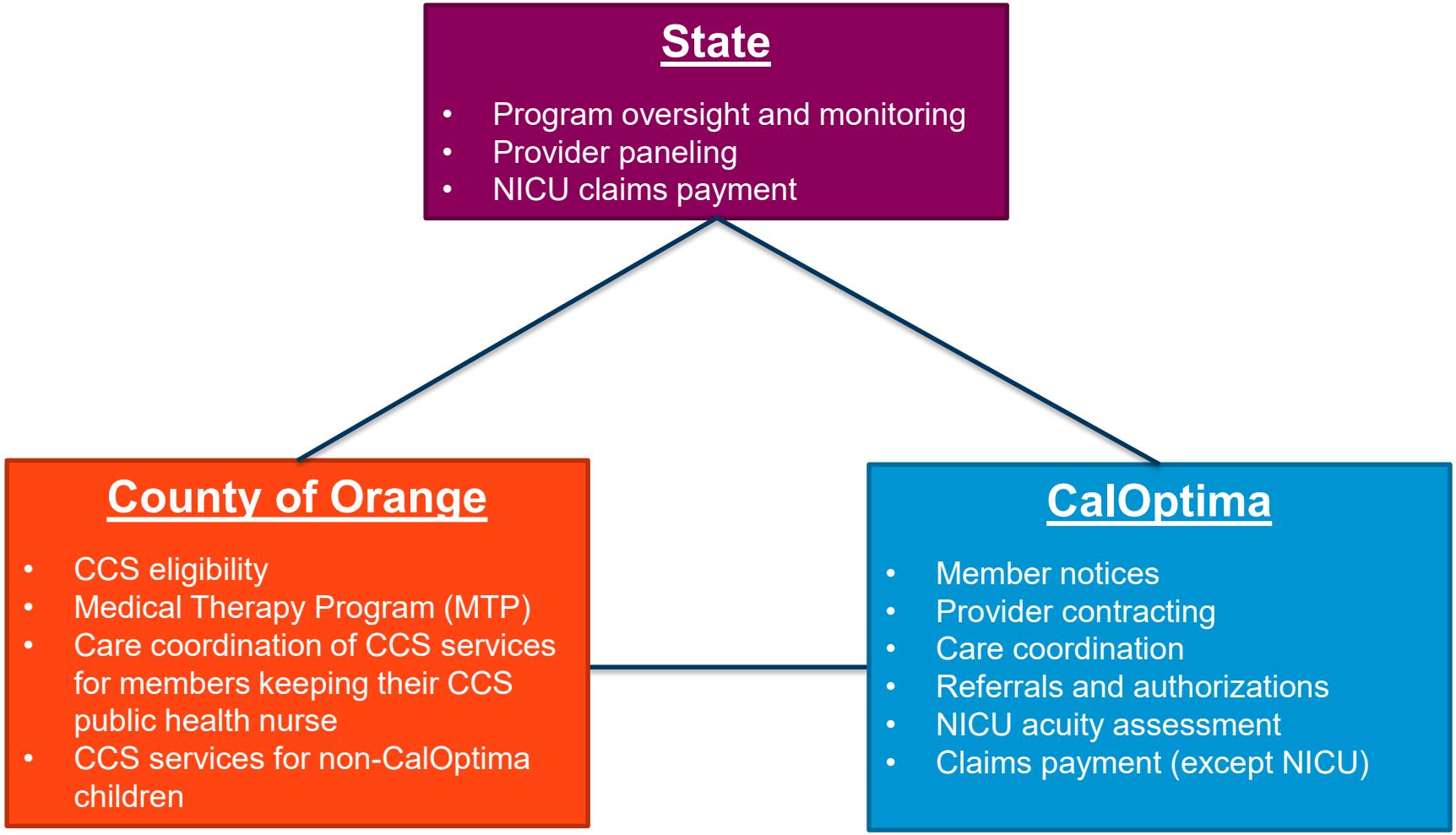
Whole-Child Model (WCM) Overview

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

Division of WCM Responsibilities



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WCM Transition Goals

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

CCS Demographics

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

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

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WCM Requirements

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

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2018 Stakeholder Engagement to Date

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

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Implementation Plan Elements

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Proposed Delivery Model

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

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

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Financial Approach

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

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Clinical Operations

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

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

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

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Provider Impact and Network Adequacy

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

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Memorandum of Understanding (MOU)

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

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WCM Family Advisory Committee

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

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WCM Family Advisory Committee (cont.)

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

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Recommended Nominees

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

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Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

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

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

Rev. 11/2/17

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

Background

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

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

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

    a. Community-based organizations; or

    b. Consumer advocates.

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

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

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

G. Stipends

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

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

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

I. WCM FAC Vacancies

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

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

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

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

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

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

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

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

1. The WCM FAC nomination ad hoc subcommittee shall:

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

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

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

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

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

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

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

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

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

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

B. WCM FAC recruitment process

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

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

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

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

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

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

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

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

C. WCM FAC nomination evaluation process

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

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

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

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

IX. GLOSSARY

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

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

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

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

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

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

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

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

_____

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

Member Name: _____ Relationship: _____

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

_____

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

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

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

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

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

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

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

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

PUBLIC RECORDS ACT NOTICE

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

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

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

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

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

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

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

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

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

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

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

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

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

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

EXPIRATION DATE:

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

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

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

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

RESTRICTIONS:

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

MEMBER RIGHTS:

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

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

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

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

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

Applicant Name: _____

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

WCM FAC Seat: _____

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

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

_____
Name of Evaluator

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

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

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

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

☐ Community-based organizations

☐ Consumer advocates

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

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

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

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

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

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

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

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

Applications must be received by March 30, 2018.

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Public Records Act Notice

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

Signature **Date**

Print Name

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CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

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

WCM FAC Seat: _____

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

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

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:
- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:
- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

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at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
9. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018-19 Capital Budget for the Facets and Cactus Upgrades

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

Recommended Action
Approve a reallocation of budgeted but unused funds of up to $470,000 from the Disaster Recovery capital project to fund the Facets and Cactus Upgrades in Fiscal Year (FY) 2018-19.

Background
On June 1, 2017, the Board approved the FY 2017-18 Capital Budget that included a capital project to improve CalOptima's Disaster Recovery process, in the amount of $950,000. At the time this budget was prepared, it was anticipated that a Disaster Recovery process similar the existing process would be enhanced or replaced following a Request For Proposal (RFP) process. A substantial investment was anticipated based on the variation in available solutions and methods for achieving adequate Disaster Recovery processes along with adequate computing hardware.

As a result of the RFP process that was completed in August of 2018, Microsoft was selected as the new Disaster Recovery vendor – and a cloud-based 'Disaster Recovery as a Service' solution was selected. Because of this model of Disaster Recovery services, the need to acquire significant amounts of computing hardware is no longer necessary and the budget requirements have decreased. In this Disaster Recovery model, in the event of a disaster, Microsoft will provide all necessary computing equipment (in their secure government cloud environment) necessary to meet CalOptima's Recovery Point and Time Objectives.

Discussion
Unrelated to Disaster Recovery, CalOptima staff is preparing for the next version upgrade to the Cognizant Facets core administrative processing system. Facets is a core system that CalOptima uses for enrollment of members, health benefit configuration, provider contracts and fee schedules, claims processing and adjudication, and customer service.. Cognizant typically releases as many as four upgrades to Facets in each calendar year. Clients can accept all, or group the upgrades, depending on resource availability for testing, etc. Typically, CalOptima upgrades Facets once per year. For the upcoming upgrade, there is an unanticipated change to the underlying database management system architecture that also necessitates an upgrade to computing hardware. This was not anticipated and increased the anticipated cost of the upgrade.

In addition, the Cactus system is also being upgraded. Cactus is the system that supports the CalOptima Provider Credentialing process. For the reasons mentioned above, the same hardware upgrade is also necessary for the Cactus upgrade.

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The cost of the required new hardware to support both upgrades is approximately $470,000. To address this unbudgeted item, Management proposes to make a reallocation of budgeted but unused funds of up to $470,000 from the capital project, Disaster Recovery, to the Facets and Cactus Upgrades.

Fiscal Impact
The fiscal impact for this recommended action is budget neutral. Unspent budgeted funds from capital project, Disaster Recovery, approved in the FY 2017-18 Capital Budget on June 1, 2017, will fund the total cost, not to exceed $470,000, for this proposed action.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *11/28/2018*
Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cognizant TriZetto Software Group, Inc. (Facets)	500 Frank W Burr Blvd	Teaneck	NJ	07666
Vendor Credentialing Service LLC, DBA Symplr (Cactus)	315 Capitol St Suite 100	Houston	TX	77002

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
10. Consider Extension of Contract Related to CalOptima's Core System, Facets

Contact
Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend the contract with Cognizant for the Facets software license and associated maintenance costs for three years, from July 1, 2019 through June 30, 2022.

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. One of those core systems is Facets. Facets handles key CalOptima operational functions including enrollment of members, health benefit configuration, provider contracts and fee schedules, claims processing and adjudication, and customer service.

Facets has been the core administrative processing system for CalOptima since April 1, 2001. This system was first developed in the 1970s, originally by a company named Erisco, and first branded as ClaimFacts. A new generation of the system was developed in the early 1990s and rebranded as Facets. Although the Facets system has been in existence a long time, it remains one of the most commonly used managed care core administrative processing systems in use today. There are 88 installations currently, covering 149 million members. There have been significant technology advances and organizational changes over time, including two acquisitions. In 2000, Erisco was acquired by TriZetto. For many years, Cognizant Technology Services was a software development partner for the Facets product. In 2014, Cognizant acquired TriZetto.

Cognizant was incorporated in 1996 and is known as one of the world's largest and leading professional services companies. As of mid-2018, Cognizant had over 250,000 employees. The acquisition of TriZetto by Cognizant complemented the service offering with extended opportunities for advanced technology development and operational support.

In 2001 when Facets was implemented at CalOptima, there were two lines of business – Medi-Cal and Healthy Families – and essentially one set of benefits, covering 249,000 members. All Health Networks accepted full risk. During the past 17 years, CalOptima's membership volume has grown to over 775,000, products such as Healthy Families were retired, new products were added, including OneCare, OneCare Connect, and PACE, and there are a variety of complex Health Network contract financial arrangements. CalOptima's business model has grown significantly more complex. As a result, CalOptima's systems, especially Facets and its interface to other systems, have had a corresponding and significant increase in

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complexity. There are currently over 300 interface points between Facets and other CalOptima systems and processes.

The original contract for Facets has been extended several times. At the June 5, 2014, meeting, the Board extended the agreement and authorized payment of maintenance and support fees through June 30, 2019. Each time, the reasons for the extension were similar – Facets has been able to continue to support the CalOptima business needs; Facets is a tightly integrated system with significant complexity; the related cost and disruption of migrating to a different system was not warranted at those times.

Although CalOptima has monitored the industry and available systems over time, Management decided that a Request For Information (RFI) was warranted this year to complete a more in-depth study of available systems and to determine if changing systems or structure was indicated. The RFI was issued in August. Ten responses/proposals were received in October. The responses/proposals were evaluated by a cross-functional work group of many operational areas and Information Services. Two were eliminated as not meeting minimum qualifications. There is enough interest in learning more about at least four of the proposals/vendors to warrant moving forward with preliminary demonstrations in January 2019. Depending on the outcomes of the demonstrations, a decision will be made to either remain on the current system or to issue a more comprehensive Request for Proposal (RFP). Proposals received in response to the RFP will help to determine if CalOptima will continue with the Facets system or migrate to a different option or solution.

Discussion

A full replacement of the Facets system would likely take two years to complete after contract execution, would require a dedicated team, and will likely incur costs of several million dollars when considering fees, expenses, and labor. One of the local Medi-Cal health plans recently completed a core system change in 24 months. Considering time required for the RFP, evaluation of responses, and contract negotiation, Management is recommending that the current contract with Cognizant for Facets be extended three years, to June 30, 2022. If a system migration takes place, this will allow sufficient time to complete the RFP and implementation.

Facets is licensed by Cognizant on a perpetual basis for membership volume. What this means is that the license includes a fee based on total membership, and an active 'member' is licensed only once. CalOptima is currently licensed for 810,000 active members; adequate volume to extend through June ~~20~~30, 2022. Cognizant has committed to no increase in maintenance fees (beyond contractual Consumer Price Index increases) for this proposed three-year extension.

Rev. 12/6/18

As a result, Staff requests authorization to extend this agreement through June 30, 2022. Staff will return to the Board with the results of the conclusion of the RFP process.

Fiscal Impact

Management will include expenses for the period of July 1, 2019, through June 30, 2022, related to the recommended contract extension in future operating budgets.

Concurrence

Gary Crockett, Chief Counsel

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Attachment
Contracted Entity Covered by this Recommended Board Action

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

11/28/2018 — **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cognizant TriZetto Software Group, Inc.	500 Frank W Burr Blvd	Teaneck	NJ	07666

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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.

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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.

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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

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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**

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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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Consider Authorizing Amendment of Existing Agreement with University of California, Irvine (UCI) Health to Extend the IGT Observation Stay Pilot Program

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Management, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute a contract amendment to the existing agreement with UCI Health to extend the Intergovernmental Transfer (IGT) Observation Stay Pilot Program (Pilot) until November 30, 2019, or until all budgeted IGT 4 funds allocated to the Pilot are depleted, whichever occurs first; and
2. Complete a final report that includes an assessment of the outcomes of the Pilot and recommendations to the Board for further action within 90 days of the completion of the Pilot.

Background

At its December 1, 2016 meeting, the CalOptima Board of Directors authorized up to $750,000 in IGT 4 dollars to fund an observation stay pilot program at UCI Health for CalOptima Medi-Cal members, subject to the parties agreeing to program terms within 90 days. Staff did not meet the 90-day time frame and at the September 7, 2017 CalOptima Board meeting, the Board authorized extending the deadline for CalOptima and UCI to reach an agreement on Pilot project terms under IGT 4 to December 31, 2017. An amendment to the Professional Services Contract between CalOptima and UCI Health to support the Pilot was executed on November 12, 2017.

The funds support a Pilot project with UCI Health to test the cost-effectiveness of Emergency Department Observation Units (EDOU) and demonstrate the potential return on investment. This project includes tracking of CalOptima member information, including diagnosis, protocol, time in EDOU, discharge diagnosis, discharge status and readmission rates and is reviewed monthly by UCI Health and CalOptima.

The amendment authorized the Pilot to begin on December 1, 2017 and to continue until the $750,000 allocated to the Pilot was depleted or November 30, 2018, whichever occurred first. CalOptima agreed to reimburse UCI Health on a case rate basis per EDOU stay for CalOptima Medi-Cal members who are part of a Shared Risk Health Network, the CalOptima Community Network or CalOptima Direct Medi-Cal. This case rate is in addition to compensation for professional and hospital services rendered, including but not limited to the emergency room visit.

Discussion

The UCI Observation Stay Pilot program for CalOptima Medi-Cal members commenced on December 1, 2017. Since the implementation of the Pilot, more than 600 CalOptima members have had Observation Stays at UCI under the program.

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The Pilot is scheduled to expire per the agreement on November 30, 2018, although approximately $300,000 of the budgeted IGT funds remain and are available to be used. Both CalOptima staff and UCI believe that additional CalOptima members with Observation Stays at UCI are necessary to determine the success of the Pilot. Demonstrating the potential return on investment of the Pilot has been difficult due to the relatively short duration of the Pilot and small number of CalOptima members with Observation Stays. Extending the Pilot until the IGT funds are exhausted would increase study duration and the number of CalOptima members who have Observation Stays at UCI. This would improve the statistical power of the Pilot evaluation and allow a better understanding of the cost effectiveness of the EDOU and the potential return on investment. With this information, Staff will be able to make more accurate recommendations to the Board as to whether to continue the program beyond the Pilot.

Fiscal Impact

The recommended action to extend the IGT Observation Stay Pilot Program from December 1, 2018 through December 31, 2019, or until the remaining budgeted IGT funds are expended has no fiscal impact on CalOptima's operating budget. Expenditure of IGT funds are for restricted, one-time purposes for the benefit of CalOptima members.

Rationale for Recommendation

As part of operating "Better. Together.', CalOptima is committed to working with Orange County's provider and community partners to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Board Action dated December 1, 2016, Consider Authorization of Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2 and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5.
2. CalOptima Board Action dated September 7, 2017, Consider Extension of Deadline for Intergovernmental (IGT) Project with University of California, Irvine (UCI) Health's Observation Stay Pilot Program

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorization of the Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2 and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve expenditure plan for reallocation of IGT 1-3 funds in the amount of $5,820,020 and allocation of IGT 4 and 5 funds in the amount of $21,966,208 to include projects consistent with the original CMS-approved expenditure categories, and that support CalOptima Board-approved funding categories;
2. Authorize the CEO to execute agreements as necessary to distribute IGT funds for Board approved projects and initiatives supporting the approved funding priorities;
3. Authorize a timeline extension for the expenditure of $50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) through June 30, 2017 or until funds have been exhausted, whichever occurs earlier; and
4. Direct staff to return to the Board with further IGT expenditure recommendations as they are developed; all IGT specific programs and initiatives remain subject to Board approval.

Background/Discussion

CalOptima began participating in the rate range IGT program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. Including the estimated amount of the currently pending IGT 5 transaction, CalOptima's share of the five IGT transactions will total approximately $48 million. Numerous Board-approved projects have been launched with IGT 1-3 funds within the regulator-approved categories, and most have been completed or are on track for completion. There are a small number of projects that have been postponed or eliminated and these dollars are available for the Board's reallocation. Allocations for IGT 4 and IGT 5 funds have yet to be approved by the Board.

1. Staff has developed recommendations to reallocate $5.8 million in unspent funds from IGTs 1-3. Recommendations have also been developed for expenditure of the $22 million in available funds from IGT 4 and IGT 5.
2. The proposed $27.8 million in recommended expenditures will be utilized to support one or more of the original CMS-approved and CalOptima Board-approved expenditure categories (see Attachment 2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories) as appropriate.

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IGT Ad Hoc Committee

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on November 14, 2016, to review the IGT expenditure plan as recommended by staff. The ad hoc committee consists of Supervisor Do, Director Nguyen, and Director Schoeffel. Recommendations from the Ad Hoc committee include the following:

1. Approve $12.8 million for projects within the approved funding categories as listed below, to improve services and quality of care for Medi-Cal member, support providers, and make infrastructure investments for the benefit Medi-Cal members.

2. Complete a comprehensive Member Health Needs Assessment, results of which will be used to inform development of Community Grant RFPs.
    a. Member Health Needs Assessment to be conducted within a 3-6 month timeframe, with the assistance of a consultant (procured according to appropriate policy and RFP processes).

3. Staff will return with recommendations for Board approval on specific programs and initiatives on the expenditure of an additional $15 million in IGT funds following completion of the Member Health Needs Assessment;

Funding Allocations and Projects to be Supported

The table below illustrates the recommended funding reallocations from IGTs 1-3 projects and allocation of IGT 4 and 5 funds:

FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
Telemedicine/ IGT 1 *(Enhance provider reimbursement rates)*	$1,000,000	Depression Screenings	$1,000,000
Telemedicine/ IGT 1 *(Strengthen delivery system)*	$69,190	Provider Portal Communications & Interconnectivity	$1,500,000
IGT 4	$1,430,810		
IGT 4	$250,000	Member Health Homes	$250,000
IGT 4	$750,000	UCI Observation Stay Payment Pilot	$750,000
IGT 4	$500,000	Member Health Needs Assessment	$500,000
IGT 4	$3,550,000	Personal Care Coordinators (PCCs)	$7,000,000
Pay-for-Performance for PCPs/ IGT 3 *(Care Coordination)*	$3,450,000		
Pay-for-Performance for PCPs/ IGT 3 *(Improve information services infrastructure)*	$750,000	Data Warehouse Expansion	$750,000
Case Management System/ IGT1 *(Strengthen delivery system)*	$3,620	Facets System Upgrade and Reconfiguration	$506,620
Provider Network Management Solution/	$500,000		

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FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
IGT 2 *(Enhance information technology infrastructure)*			
Security Audit Remediation/ IGT2 *(Enhance information technology infrastructure)*	$3,000		
Additional Unallocated Funds/ IGT 1	$28,231	IGT Program Administration (Grants Management Software, staffing and administrative costs)	$529,608
Additional Unallocated Funds/ IGT 2	$427		
Additional Unallocated Funds/ IGT 3	$15,552		
IGT 4	$485,398		
		Subtotal	**$12,786,228**
IGT 5 (Anticipated amount)	$15,000,000	Community Grants (pending completion of Member Health Needs Assessment)	$15,000,000
		Total	**$27,786,228**

The details of the above recommended projects are as follows:

- Depression Screenings (up to $1,000,000): Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members ages 12-18 over two years. Subject to regulator approval, as applicable, incentive payments per screening will be $30 and made directly to primary care providers. Beginning with Year 2 of the project, and again, subject to regulator approval as appropriate, a sufficient process/infrastructure must be in place to collect depression screening scores in addition to the claims from providers in order for incentive payment to be made. This project addresses the "Children's Mental Health" funding category.

- Provider Portal Communications and Interconnectivity (up to $1,500,000): Develop and implement a web-based provider portal strategy that will support real time bi-directional electronic communication between CalOptima and community partners/providers. Project includes an initial pilot with designated community agencies to evaluate and incorporate feedback prior to implementation with CCN Network Providers. This project addresses the "Pilot Program Planning and Implementation" funding category, as bi-directional data sharing and exchange between CalOptima and providers is a required component of the Whole Person Care pilot in which CalOptima is a key participant, and will be an important asset to the upcoming Health Homes Program.

- Health Homes Program (HHP) (up to $250,000): CalOptima is implementing the "Health Homes for Patients with Complex Needs Program" (HHP), a new DHCS program for Medi-Cal and Cal Medi-Connect plans. This program requires plans to engage Community-Based

Care Management Entities (CB-CMEs) to provide HHP services. DHCS requires plans to assess organizations in the community that may offer HHP services and use this information in development of the local delivery model. Health Homes Program payments do not cover the cost of such activities, and IGT funds will be used to complete this one-time environmental assessment and development of tools to select, contract and determine readiness of organizations to provide HHP services. These activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the "Pilot Program Planning and Implementation" funding category.

- UCI Observation Stay Payment Pilot (up to $750,000): Assuming terms and can be reached with UCI within 90 days, funds will support a pilot project with UC Irvine Health to test cost effectiveness of emergency department observation unit (EDOU) care and demonstrate potential return on investment for such care. This project will include tracking of specific CalOptima member information, including diagnosis, protocol, time in EDOU, discharge diagnosis, discharge status and readmission rates. UCI and CalOptima will conduct monthly utilization review. If terms cannot be reached within this time period, staff will return to the Board with further recommendations. This project addresses the "Pilot Program Planning and Implementation" funding category.

- Member Health Needs Assessment (up to $500,000): Conduct a county-wide Medi-Cal member health needs assessment. Funds will support assistance from a consultant (procured according to appropriate policy and RFP processes) and associated costs for assessment activities such as surveys, focus group meetings and survey completion incentives etc. Results and recommendations from the completed assessment will inform RFP development of targeted Community Grant funding to support the needs of Medi-Cal beneficiaries in Orange County. This project addresses the "Strengthening the Safety Net" funding category by providing information that will more effectively align funding investments with the needs of our Medi-Cal members.

- Personal Care Coordinators (PCCs) (up to $7,000,000): Funds will support Health Network and CalOptima PCCs to assist members in navigating the health care system. Funding covers PCCs for the following member populations: duals (OneCare and OneCare Connect), Medi-Cal Seniors and Persons with Disabilities, and other vulnerable populations (e.g, homeless, those with serious and persistent mental illness, transitioning from Regional Center services, etc.). Funding includes support for the cost of services to complete an evaluation of the PCC program, to be completed no later than June 2018. Evaluation activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the "Strengthening the Safety Net" funding category as PCCs assist members in navigating the health care system.

- Data Warehouse Expansion ($750,000): Integrate various data sources (e.g. pharmacy, claims, case management system, accounting and budget data) into the Clinical Data Warehouse to provide the capability to build complete member claims and pharmacy histories, analyze data

and produce an integrated performance/financial impact analysis package. This project is anticipated to be completed in two years or less and may include the use of contract services and information systems upgrades procured according to appropriate policy and RFP processes. This project addresses the "Pilot Program Planning and Implementation" funding category, as data integration is a fundamental component of the Whole Person Care pilot, Health Homes Program, and Whole Child initiatives.

- Facets System Upgrade and Reconfiguration (up to $506,620): Improve operational efficiencies of Facets claims and member management system with additional hardware and vendor service purchases. This work supports optimizing data storage requirements and prevents data loss, adding test environments for program implementation to mitigate negative impact to production, system load balancing to support growth in membership and claims data, and improving performance and batch processing to optimize server distribution. This project addresses the "Enhance core data analysis and exchange systems" funding category, being continued from IGT 2.

- IGT Program Administration (up to $529,608): Funds will support purchase and ongoing maintenance of Grant Administration software (procured according to appropriate policy and RFP processes) to facilitate management and oversight of IGT projects and community grants. Funding will also support staffing and administrative costs to manage the IGT transaction process, and provide IGT project and expenditure oversight over two years. Administrative functions are an allowable use of IGT funds and support the funding category of "Strengthening the Safety Net" by providing oversight of the entire IGT process and ensuring that funding investments are effectively aligned with the needs of our members.

- Addressing Gaps and Barriers facing Orange County Medi-Cal members (approximately $15,000,000): $15,000,000 in anticipated funds from IGT 5 to be allocated for targeted community needs in one or more of the funding priority areas above after completion of a Member Health Needs Assessment. Staff will return to the Board with recommendations following completion of the Health Needs Assessment.

IGT 1 Project Timeline Extension

As part of this expenditure plan recommendation, staff also requests a timeline extension for an expenditure of $50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) which was authorized through December 31, 2016 (see Attachment 14, Board Action dated March 3, 2016 - Authorize Extension and Reallocation of OneCare PCC Funds for CY 2016). Extension for use of these funds is requested through June 30, 2017 or until funds have been exhausted, whichever occurs earlier.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

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Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT Update and Expenditure Plan
2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories
3. Board Action dated March 7, 2013: Approve Proposed Use of $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents
4. Board Action dated June 6, 2013: Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds
5. Board Action dated March 6, 2014: Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents
6. Board Action dated September 4, 2014: Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of $900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services
7. Board Action dated October 2, 2014: Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)
8. Board Action dated December 4, 2014: Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants
9. Board Action dated December 4, 2014: Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
10. Board Action dated April 2, 2015: Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program
11. Board Action dated April 2, 2015: Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

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12. Board Action dated May 7, 2015: Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)
13. Board Action dated October 1, 2015: Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects
14. Board Action dated March 3, 2016: Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

/s/ Michael Schrader — *11/23/2016*

Authorized Signature — **Date**

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IGT Update & Expenditure Plan

Board of Directors Meeting
December 1, 2016

Cheryl Meronk
Director, Strategic Development

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Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

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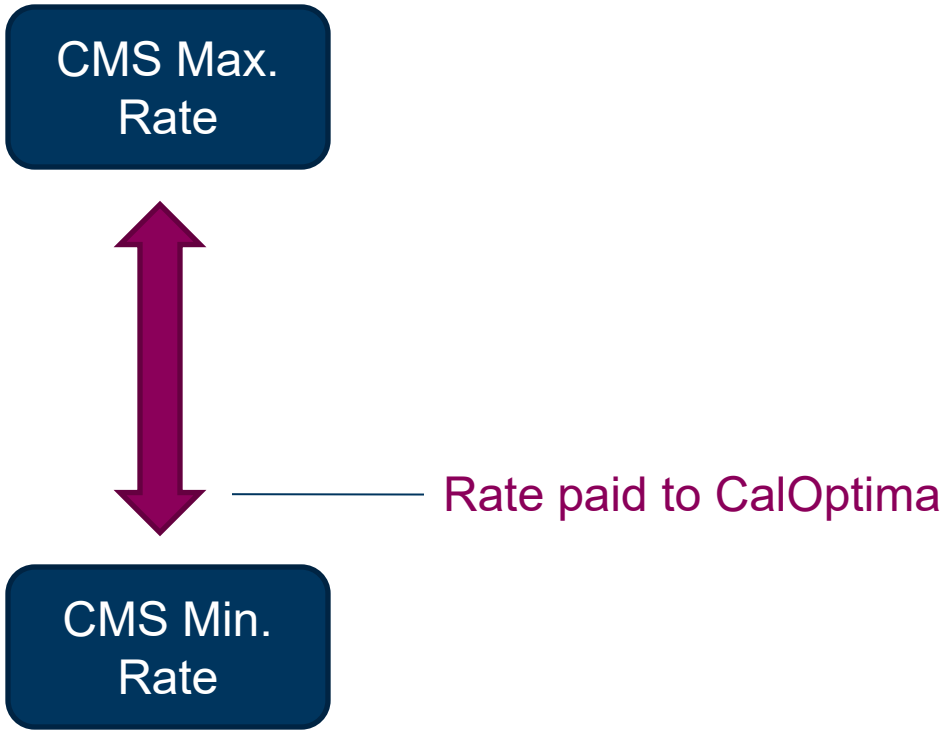
Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



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IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

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CalOptima Share Totals for IGT 1–5

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$7 M
IGT 5	≈$15 M
Total	**$48 M***

**Estimated total*

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IGT 1 Status*

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$110,000	Complete by 2/28/2017
Case Management System	$2,099,000	$3,500	Completed
Strategies to Reduce Readmissions	$533,585	$443,000	Complete by 12/1/2016
Program for High-Risk Children	$500,000	$500,000	Complete by 10/31/2018
Telemedicine	$1,100,000	$1,100,000	To be reallocated
Case Management System Consulting	$866,415	$218,000	Complete by 12/31/2017
OCC PCC Program	$3,550,000	$2,085,000	Complete by 2/28/2017
Total	**$12.5 M**	**$4.4 M**	**Total Reallocation Amount: $1.1 M**

**As of 8/31/2016 – balance figures rounded*

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IGT 2 Status*

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,250,000	$265,000	Complete by 12/31/2016
Security Audit Remediation	$101,000	$0	Completed
Continuation of COREC	$1,000,000	$517,000	Complete by 6/30/2017
OCC PCC Program	$2,400,000	$2,400,000	Complete by 3/31/2018
Children's Health/ Safety Net Services	$1,300,000	$126,000	Complete by 5/31/2017
Wraparound Services	$1,400,000	$487,000	Complete by 11/1/2017
Recuperative Care	$500,000	$318,500	Complete by 3/1/2017
Provider Network Management Solution	$500,000	$500,000	To be reallocated
Project Management	$100,000	$17,000	Complete by 9/30/2016
PACE EHR System	$50,000	$1,000	Complete by 12/31/2016
Total	**$8.6 M**	**$4.6 M**	**Total Reallocation Amount: $0.5 M**

**As of 8/31/2016 – balance figures rounded*

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IGT 3 Status*

Project	Budget	Balance	Notes
Pay for Performance for PCPs	$4,200,000	$4,200,000	To be reallocated
Recuperative Case (Phase 2)	$500,000	$500,000	Complete by 6/30/2018
Project Management	$165,000	$165,000	Complete by 12/31/2017
Total	**$4.8 M**	**$4.8 M**	**Total Reallocation Amount: $4.2 M**

**As of 8/31/2016 – balance figures rounded*

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IGT 4 Status*

Project	Budget	Balance	Notes
Unallocated Funds	$7,000,000	$7,000,000	To be allocated
Total	**$7 M**	**$7 M**	**Total Allocation Amount: $7 M**

**As of 8/31/2016 – balance figures rounded*

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IGT 5 Status*

Project	Budget	Balance	Notes
Unallocated Funds	≈$15,000,000	≈$15,000,000	To be allocated
Total	**≈$15 M**	**≈$15 M**	**Total Allocation Amount: ≈$15 M**

**Not yet received*

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Total Funds to Reallocate or Allocate

IGT	Funds Available
IGT 1	$1.1 M
IGT 2	$0.5 M
IGT 3	$4.2 M
IGT 4	$7 M
IGT 5	≈$15 M
Total	**$27.8 M***

**Estimate dependent on total IGT 5 amount*

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IGT Approved Funding Categories*

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Strengthening the Safety Net
- Improving Children's Health
- Pilot Program Planning & Implementation

**IGTs 4 and 5 only*

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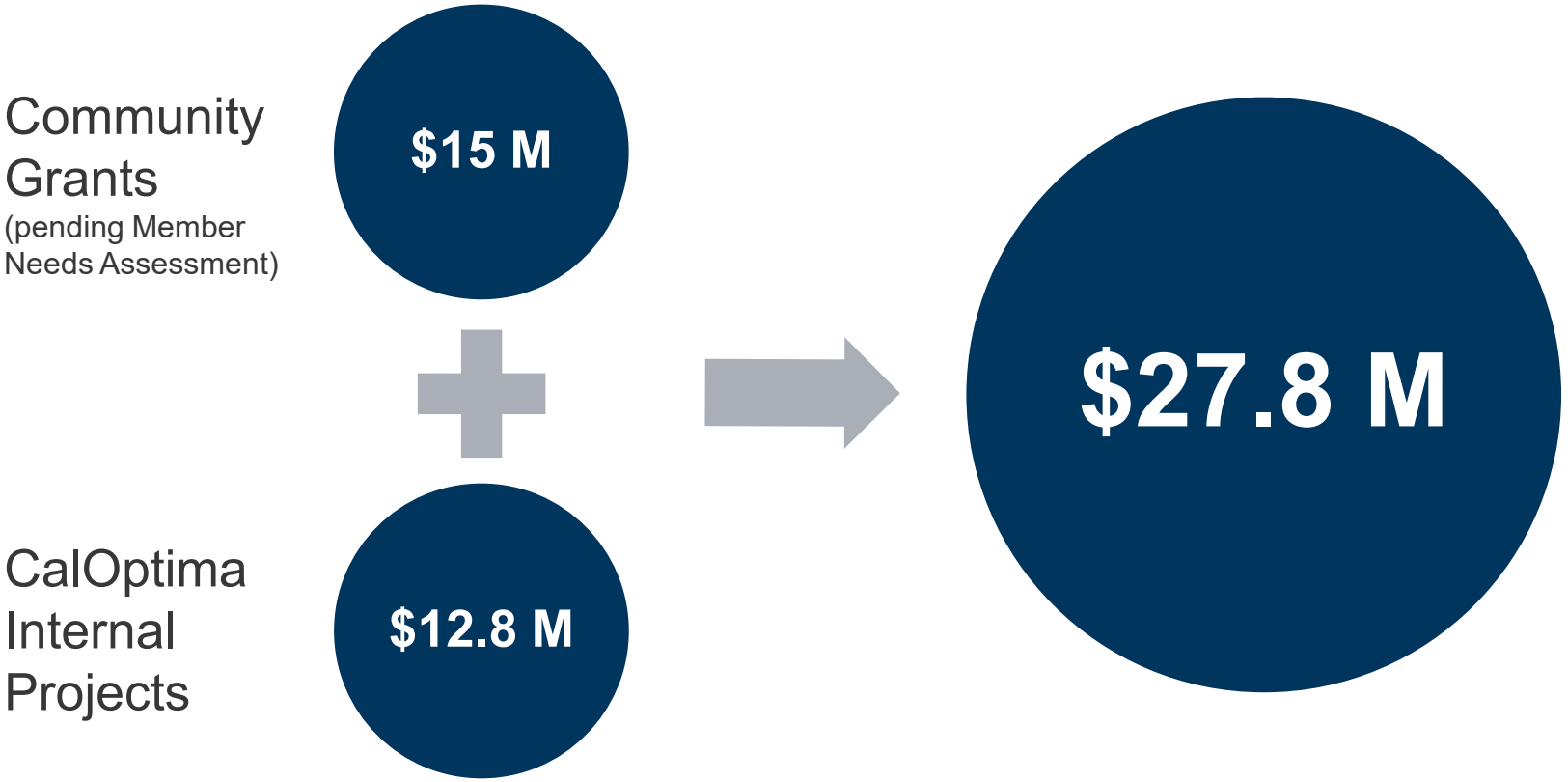
Purpose of IGT Funds

- Funds must be used to deliver enhanced services for the Medi-Cal population



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Recommended Internal Expenditures

Expenditures	Funding Amount
Data Warehouse Expansion	$750,000
Depression Screenings Ages 12–18	$1,000,000
Facets System Upgrade and Reconfiguration	$500,000
Health Homes Program	$250,000
Health Needs Assessment	$500,000
IGT Program Administration (grant management software, staff and administrative costs over two years)	$530,000
Personal Care Coordinators (PCCs) • Duals (OneCare and OneCare Connect) • Medi-Cal Seniors and Persons with Disabilities • Other Populations (Homeless/SPMI, RCOC, etc.)	$7,000,000
Provider Portal Communications and Interconnectivity	$1,500,000
UCI Observation Stay Payment Pilot	$750,000
Total	**$12,780,000**

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External Community Grant Support

- Comprehensive Member Health Needs Assessment to inform Grant RFP development
  - Fill gaps in services and improve health outcomes for CalOptima members
  - Improve access to services
  - Address social determinants of health
- Orange County's Medi-Cal delivery system relies heavily on safety net system
  - Community health centers
  - Community-based organizations

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IGT Timeline

Date	Activity
September 15	FAC Update and Review
September 21	QAC Update and Review
November 10 and 17	PAC/MAC/OCC MAC Review
November 14	IGT Ad Hoc
December 1	Board of Directors Presentation
January – June 2017	Conduct Member Health Needs Assessment
Fall 2017	Development and Release of Community Grant RFPs

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IGT 1-5 Summary Tables of Expenditure by CMS/DHCS (and CalOptima Board) Approved Funding Categories

IGT 1 Funding Categories: (CalOptima Board Approved on March 7, 2013)

- Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not limited to, the following:
  - Open access scheduling
  - Same day appointment availability
  - Participation in medical homes
  - Specialist recruitment for increased access
- Strengthen the delivery system to include, but no be limited to, increased member education and previously unused or underused resources such as the following:
  - 24/7 clinical call center
  - Minute clinics
  - Telemedicine
  - E-consults
  - Complex case management

Project	Amount	Funding Category
OneCare Personal Care Coordinators	$3,850,000	Strengthen the delivery system
Case Management System	$2,099,000	Strengthen the delivery system
Strategies to Reduce Re-admissions	$533,585	Strengthen the delivery system
Program for High Risk Children	$500,000	Strengthen the delivery system
Telemedicine	$1,100,000	Enhance provider reimbursement rates
Case Management System Consulting	$866,415	Strengthen the delivery system
OCC PCC Program	$3,550,000	Strengthen the delivery system
Total Allocation	**$12.5 M**	

IGT 2 Funding Categories: (CalOptima Board Approved on March 6, 2014)

- Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
- Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
- Provided wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventative dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventative health programs.

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Project	Amount	Funding Category
Facets System Upgrade & Reconfiguration	$1,250,000	Enhance information technology infrastructure
Security Audit Remediation	$101,000	Enhance information technology infrastructure
Continuation of COREC	$1,000,000	Enhancement to core data systems
OCC PCC Program	$2,400,000	Strengthen the delivery system
Children's Health/Safety Net Services	$1,300,000	Strengthen the delivery system
Wraparound Services	$1,400,000	Wraparound services
Recuperative Care	$500,000	Strengthen the delivery system
Provider Network Management Solution	$500,000	Enhancement to core data systems
Project Management	$100,000	Administration
PACE EHR System	$50,000	Enhance information technology infrastructure
Total Allocation	**$8.6 M**	

IGT 3 Funding Categories: (CalOptima Board Approved on September 4, 2014)

- Services related to care coordination and case management for CalOptima members;
- Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;
- Innovation and enhancement of the health care delivery model
- Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

Project	Amount	Funding Category
Pay for Performance for PCPs	$4,200,000	Care coordination
Recuperative Case (Phase 2)	$500,000	Strengthen the delivery system
Project Management	$165,000	Administration
Total Allocation	**$4.8 M**	

IGT 4 Funding Categories: (CalOptima Board Approved on May 7, 2015)

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health;
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and implement pilot programs as required.

Project	Amount	Funding Category
Unallocated Funds	$7,000,000	To be distributed across categories
Total Allocation	**$7 M**	

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IGT 5 Funding Categories: (CalOptima Board Approved on April 7, 2016)

- Adult Mental Health
- Childhood Obesity
- Children's Mental Health
- Improving Children's Health
- Strengthening the Safety Net
- Pilot Program Planning and Implementation

Project	Amount	Funding Category
Unallocated Funds	$15,000,000	To be distributed across categories
Total Allocation	**$15 M**	

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VII. A. Approve Proposed Use of $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve proposed use of $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds; and
2. Authorize the CEO to initiate the required process for FY 2011-12 IGT funds and execute required IGT documents.

Background

On March 3, 2011, the CalOptima Board approved staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained $12.4 million through the IGT transaction. The funds were received in late August 2012, and UCI's portion was disbursed in September.

IGTs are transfers of public funds between governmental entities. The revenue generated through IGTs is potentially non-recurring since there is no guarantee of future IGT agreements. Thus, funds are best suited for one-time investments or as seed capital for new services or initiatives. Ultimately, IGT-funded programs or services must be self-sustaining and not reliant on IGT funds for ongoing operation.

In approving the IGT, the Centers for Medicare & Medicaid Services (CMS) authorized the use of IGT funds to fulfill one or more of the options under the following categories, as approved by the CalOptima Board of Directors:

Category 1: Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not necessarily limited to, the following:

a. Open access scheduling
b. Same day appointment availability
c. Participation in medical homes
d. Specialist recruitment for increased access

Category 2: Strengthen the delivery system to include, but not be limited to, increased member education and previously unused or underused resources such as the following:

a. 24/7 clinical call center
b. Minute clinics
c. Telemedicine

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d. e-Consult
e. Complex case management

Discussion

CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each potential use. In response to a request from both committees for a cost analysis of the CMS-approved uses, Manatt, an interdisciplinary policy and business advisory consultancy firm, was engaged to research and prepare the requested analyses within an accelerated timeframe. A copy of Manatt's analysis is attached.

The MAC and the PAC met twice and formed ad hoc groups to review Manatt's analysis and provide recommendations for use of the funds. Based on this input, staff developed a proposal that is presented in the attached presentation.

Prior to moving forward, staff will return to the Board for approval of a proposed implementation plan.

Proposed Uses	Recommended Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

UCI has indicated interest in entering into an agreement for a second IGT for FY 2011-12. As proposed, CalOptima plans to begin working with UCI on the required process.

Fiscal Impact

FY 2010-11 IGT funding provides $12.4 million to improve the quality of care and cost effectiveness of CalOptima and its delegated network. Potential funds for FY 2011-12 are unknown at this time.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

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Concurrence
Gary Crockett, Chief Counsel
Michael Ewing, Chief Financial Officer

Attachments
FY 2010-11 IGT Recommendations Presentation
Manatt Cost Analysis dated January 10, 2013

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

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Recommendations for FY 2010-11 Intergovernmental Transfer (IGT) Funds

Board of Directors Meeting
March 7, 2013

Ilia Rolon, MPH
Manager, Strategic Operations

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Planning Process

- Engaged Manatt Consulting to:
  - Estimate upfront costs, costs to sustain
  - Identify implementation barriers and opportunities
- Presented analysis to Provider Advisory Committee (PAC) and Member Advisory Committee (MAC) in January 2013
- C and MAC
  - Held ad hoc meetings in January to review analysis in more depth and receive staff input
  - Met in February to vote on priority of options and finalize recommendations to CalOptima Board
  - Consensus reached between PAC and MAC regarding top four priorities

Options

Previous Name	New Name
Complex case management	•Complex case management
Open access scheduling	•Extended hours
Same day appointment availability	•Combined with above
Participation in medical homes	•Medical home infrastructure support
Specialist recruitment	•Specialist recruitment and retention
24/7 clinical call center	•Clinical call center
Minute clinics	•Alternative access points
Telemedicine	•Remote visits •Telemonitoring
E-Consults	•Specialty Care Consults

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Comparison of Recommendations

Priority	Provider Advisory Committee	Member Advisory Committee
1	**Complex Case Management**	**Complex Case Management**
2	**Specialty Care Access -- Planning & Pilots**	**Extended Hours**
3	**Extended Hours Access**	**Alternative Access Points**
4	**Alternative Access Points – Planning and Pilots**	**Specialty Care Access – Planning & Pilots**
5		Remote Visits
6		Medical Home Infrastructure Support
7		Telemonitoring

* Bold type indicates consensus

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Staff Recommendations

Proposed Uses	Recommended Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical risk	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented ROI, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Complex Case Management – Part 1

- Recommended Allocation: $9.3 Million
- Description
  - Case management and care coordination services for high-need members across various provider settings (e.g., primary and specialty care, inpatient, skilled nursing)
  - A platform for IGT-funded services: Case Management team determines which other services the member needs
- Pricing Elements
  - Approximately 15 positions (HIT staff, RNs, data analysis, patient navigators)
  - New or enhanced technology for:
    - care coordination
    - clinical decision support
    - data repository
    - electronic health record (EHR) integration
    - predictive modeling

Complex Case Management – Part 2

- Recommended Allocation: $2 Million
- Description
  - Improvement of Health Networks' ability to accurately document clinical need
- Pricing Elements
  - Gap analysis
  - Risk documentation software
  - Staffing for provider technical assistance and education

Expanded Access Pilots

- Proposed Allocation: $1.1 Million
- Objectives
  - Reduction in visits to emergency departments
  - Decreased wait times for specialty care
  - Improved member satisfaction
- Potential Pilots
  - E-Consultation: Enables PCP to meet and share information with specialist via web connection and refer electronically for treatment, thus reducing need for specialty care
  - Incentivizing providers to see patients during evening and weekend hours
  - Developing alternative access points
  - Telemonitoring

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Next Steps

- Approve Staff Recommendation for use of IGT funds
- Receive implementation plan in April / May 2013

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. E. Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds

Contact
Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Action
Approve work plan and timeline for proposed use of $12.4 million of FY 2010-11 Intergovernmental Transfer (IGT) funds.

Background
On March 3, 2011, the CalOptima Board authorized staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained $12.4 million through the IGT transaction.

Subsequent to receiving the funds in late August 2012, CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each CMS-approved potential use. In response to a request from both committees for a cost analysis of the potential uses, Manatt, an interdisciplinary policy and business advisory consulting firm, was engaged to research and prepare the requested analyses. The MAC and the PAC reviewed Manatt's analysis and provided recommendations for use of the funds. Based on this input, staff developed a proposal for best use of the funds.

On March 7, 2013, the CalOptima Board approved three main uses of the funds to improve the quality of care and cost effectiveness of CalOptima and its delegated network, as shown in the table below. The approved uses are expected to generate the most positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Approved Uses	Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

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Discussion
The largest portion of FY 2010-11 IGT funds is allocated to the enhancement of complex case management services for high-risk members across various care settings. Per the medical literature, the success of such programs is highly dependent on who is targeted, the program's design, and how success is measured. To derive maximum benefit from its investment in disease and case management services, CalOptima will first seek to strengthen the existing infrastructure in the following two areas: 1) improvement of data integrity and completeness; and, 2) implementation of predictive modeling to further inform the enrollment of members in disease and complex case management programs. In Phase Two, staff will use improved data to design complex case management program enhancements and determine the optimal delegation arrangement for these services.

IGT funds were also earmarked for pilot projects that expand access to healthcare services, particularly for medically vulnerable members. In FY 2013-14, CalOptima will implement a pilot to enhance communication between primary and specialty care providers through electronic referrals and consultations. The goals of the pilot are to mitigate specialty care service capacity issues and increase the ease and efficiency with which members who need specialty care services are able to access those services.

A more detailed work plan and timeline is included in the attached presentation. Staff will provide quarterly reports on the implementation progress.

Fiscal Impact
Implementation plan is consistent with previously approved IGT for FY 2010-11.

Rationale for Recommendation
The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

Concurrence
Gary Crockett, Chief Counsel
Michael Ewing, Chief Financial Officer

Attachment
FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

/s/ Michael Schrader — *5/31/2013*
Authorized Signature — **Date**

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FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

Board of Directors Meeting

June 6, 2013

Ilia Rolon, MPH

Director, Strategic Development

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Background

March 2013 Board Actions

- Approved use of IGT funds as follows:
  - Complex Case Management (CCM) 1: Case management for high-risk members across various care settings
    - Year 1: $5.1M
    - Year 2: $4.2M
  - CCM 2: Improved health network documentation of clinical risk
    - Year 1: $1.8M
    - Year 2: $200K
  - Pilot selected expanded access strategies such as e-consults, telemonitoring, and alternative access points
    - Year 1: $450K
    - Year 2: $650K
- Directed staff to return with implementation plan

Key Planning Assumptions

- Success of case and disease management programs is highly dependent on who is targeted, how program is designed and how success is measured*
- Allocation of funding should be data-driven
    - Begin by strengthening CalOptima's ability to accurately identify patients that fall within targeted risk score range
- Resources should follow the critical mass of at-risk members

* *Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare oundation, April 2013*

Work Plan and Timeline

- **Strengthen complex case management infrastructure**
  - Improve data integrity and completeness
    - **Q3 2013** Assess current CalOptima data integrity; Issue RFP for vendor to provide technical assistance to health networks (HN) and providers for improved documentation of risk (CCM 1 & 2)
    - **Q4 2013** Upon selection of vendor, enroll interested HNs and conduct assessments (CCM 2)
    - **Q1 2014** Based on assessment results, identify opportunities for improvement and offer consultative assistance to HNs (CCM 2)
    - **Q2 2014** Use improved data to design, implement CCM program enhancements and determine delegation arrangement (CCM1)
  - Implement predictive modeling to further inform enrollment in complex case management programs (CCM 1)
    - **Q2 2014** Issue RFP
    - **Q3 2014** Select vendor and begin implementation and training
    - **Q4 2014** Implement enhancements to member enrollment

Work Plan and Timeline (Cont.)

- **Enhance referral and consultation communication between primary and specialty care providers**
  - **Q3 2013** Assess current health information exchange capabilities (CalOptima web portal, OCPRHIO*) and determine buy or build
  - **Q4 2013** Issue RFP for e-consult platform, if needed
  - **Q1 2014** Install components
  - **Q2 2014** Pilot with 1 health network and select CCN providers
  - **Q2-Q3 2014** Enroll other interested health networks and CCN providers

* Orange County Partnership Regional Health Information Organization

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Appendix

- Types of Care Management Programs
- California Healthcare Foundation Recommendations

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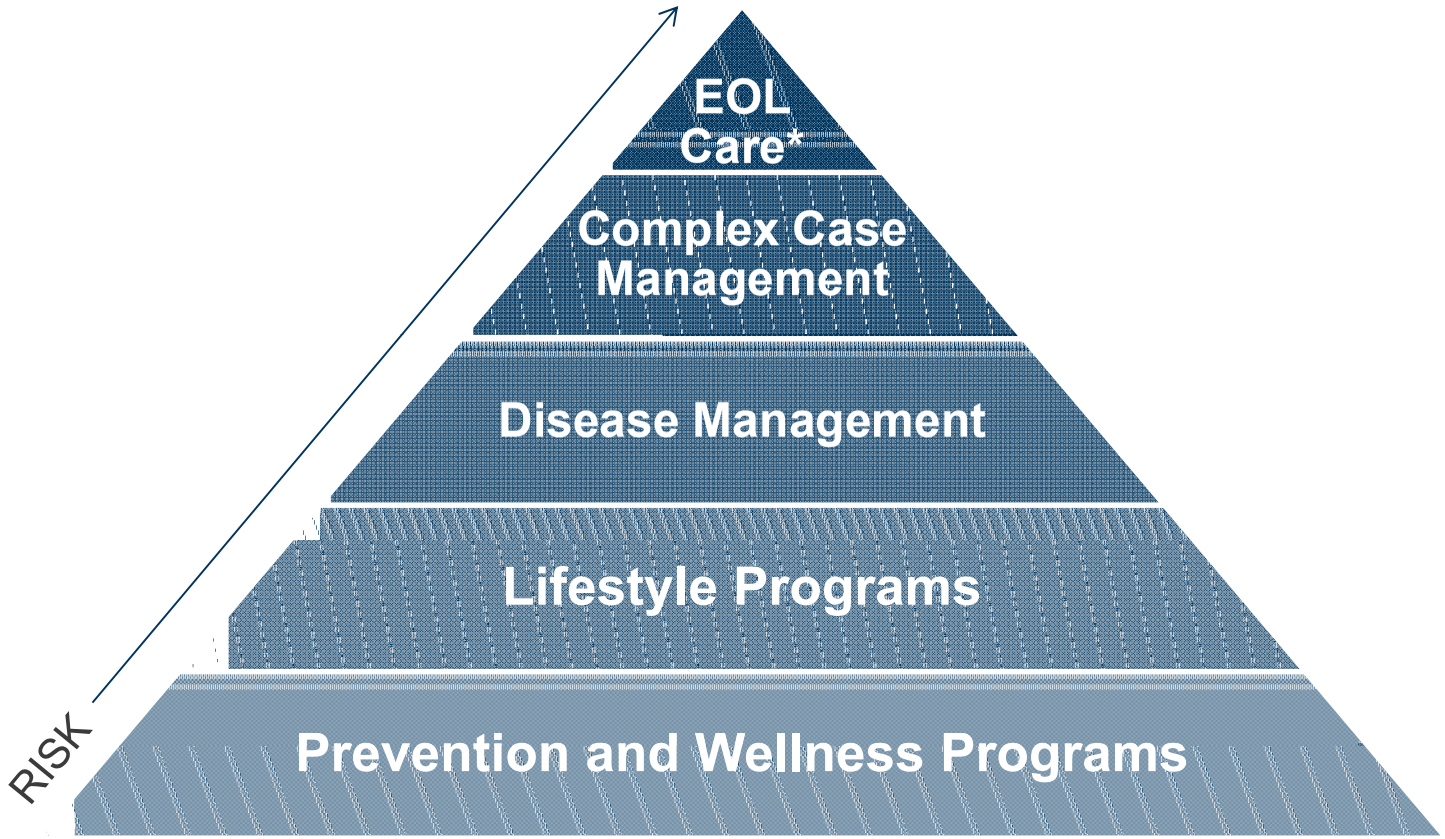
Types of Care Management Programs



* End-of-life care (may be considered part of complex case management or may be separate rogram

Source: Booz Allen Hamilton, 2012

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California Healthcare Foundation Recommendations

- Use analytic tools to better identify the population that would most benefit from interventions
  - *Predictive modeling*: Statistical technique of analyzing data to predict which members may be at greater risk for high-cost care, esp. hospitalization
- Adjust program design to engage and activate the patient by experimenting with a wide range of tools
  - "Low-touch": Tech solutions such as mobile apps, text messaging
  - "High-touch": Coaching or case management
- Better integrate disease management and complex case management programs with the treating provider or PCP
  - Use contracting arrangements to better align financial incentives and outcome measurement
  - Test a range of provider engagement tools, such as health information exchanges (HIEs), provider portals and embedding of care managers

Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare Foundation, April 2013

Intergovernmental Transfers (IGT)

Board of Directors Meeting
March ~~7~~ 6, 2014

Ilia Rolon
Director, Strategic Development

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Background

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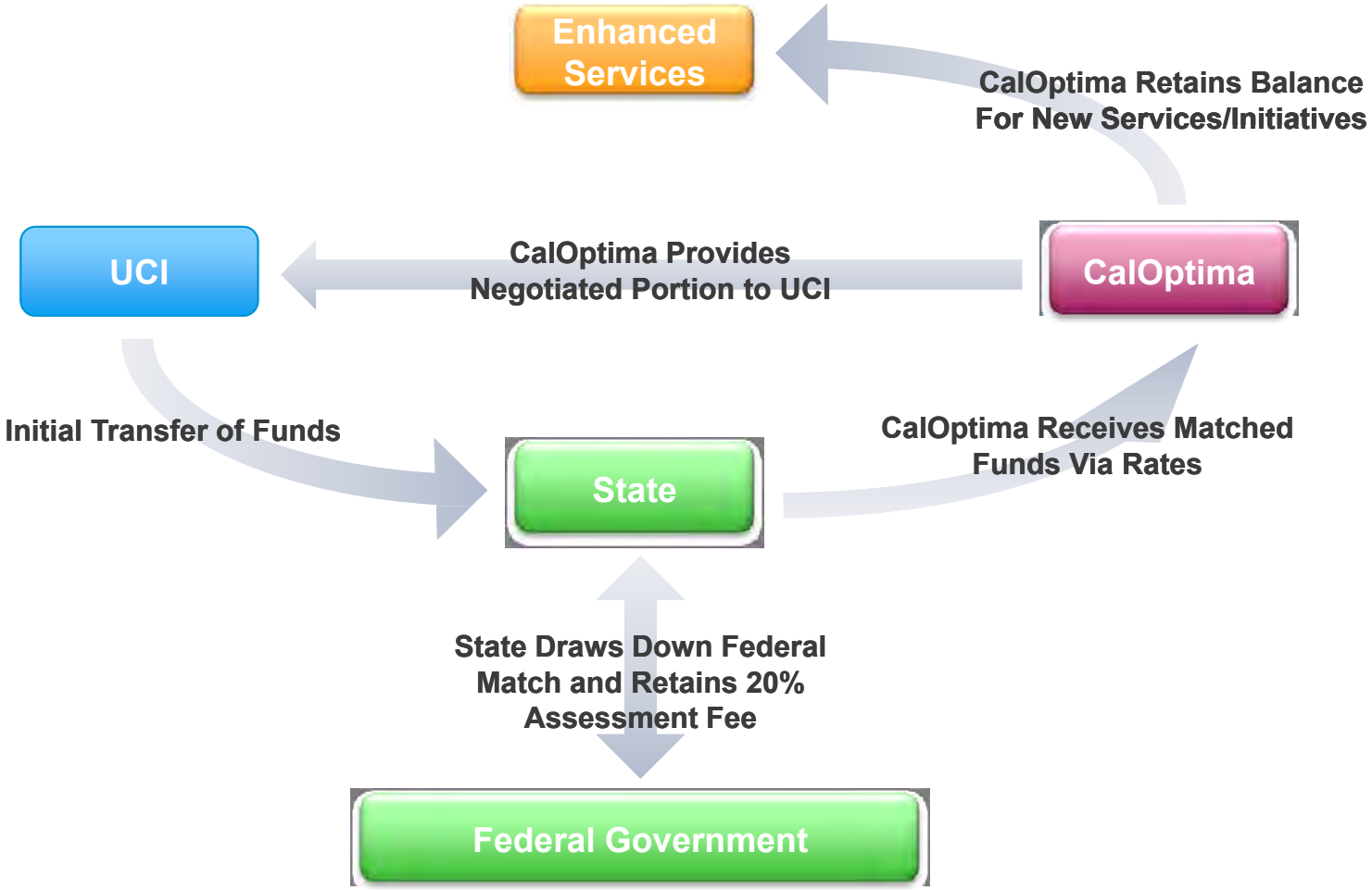
About IGTs

- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
  - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
    - California: 50%
    - Mississipi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

IGT Transaction Overview



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Use of Funds

- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	**$12.4 M**	**$8.4 M***	$3.1 M	$23.9 M
IGT 2	FY 11-12	2013	**$7.4 M**	**$4.8 M**	$5.4 M	$17.6 M
Total Funds			**$19.8 M**	**$13.2 M**	$8.5 M	$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: $2 M contract award for new case management system; agreements with health networks for approximately $2 M in funding for personal care coordinators pending

* UCI's net revenue was $3.4 Million due to exclusion from approximately $5.0 million in state disproportionate share (DSH) payments

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Proposal

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IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	$5.1 M	$4.2 M	–	–	
Personal Care Coordinators	$1.85 M	$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	$2.0 M	$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	$1.0 M	$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	$250 K	$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
Complex Case Management II	**$1.8 M**	**$200,000**	**N/A**	**N/A**	**Merge this category with CCM 1**
Access Strategies	$450,000	$650,000	–	–	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	$7.35 M	$5.05 M			

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Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation
Enhanced Core Systems • Facets system upgrade and reconfiguration • Provider network management solution • Security audit remediation • Funding to continue COREC services for two years	**$3.0 M**
Continued / Expanded IGT 1 Services •Personal care coordinators •Strategies to reduce hospital readmissions	**$3.0 M**
Wraparound Services & Optional Benefits • To be developed further. • May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits.	**$1.4 M**
Total Funds	**$7.4 M**

60% for direct services

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Next Steps

- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve final expenditure plan for $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for $7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained $12.4 Million, UCI retained $8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained $7.4 million, UCI retained $4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

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Table 1. Approved Expenditure Plan for IGT 1	**Budget**
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	**Budget**
Complex Case Management • Case management for high-risk members across various care settings, including improved documentation of clinical risk	Year 1: $6.9M Year 2: $4.4M
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Proposed Expenditure Plan for IGT 2
As previously stated, CalOptima retained $7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

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1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	**Budget**
Enhancement of Core Data Systems	$3.0 M
Continuation/Expansion of IGT 1 Initiatives	$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	$1.4 M
Total Budget	**$7.4 M**

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

2/28/2014 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. B. Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of $900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Authorize the Chairman of the Board of Directors to execute an amendment to the primary agreements among DHCS, UCI, and CalOptima for the upcoming FY 2012-13 IGT (IGT 3), including approval of proposed general use categories;
2. Approve final IGT 2 budget of $8.7 million and allocate the additional $1.3 Million to children's health and/or safety net services; and
3. Consider proposal for school-based vision and dental wraparound services for children enrolled in Medi-Cal, in amounts not to exceed $500,000 for vision services and $400,000 for dental services.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date, with a third IGT pending for FY 2012-13.

Presently staff recommends two actions related to the pending IGT 3 transaction, and two pertaining to FY IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

Discussion

IGT 3 Application

On June 20, 2014, CalOptima and UCI submitted a proposal to DHCS for a third IGT. If approved, the proposed IGT will result in revenue of approximately $4.8 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in September 2014. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 3 funding. Additionally, consistent with the proposal to DHCS submitted in June 2014, staff requests approval of four general categories of uses for IGT 3 revenue as follows:

1. Services related to care coordination and case management for CalOptima members;
2. Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;

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3. Innovation and enhancement of the health care delivery model;
4. Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

A budget allocation for the proposed categories will be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the state.

Additional IGT 2 Revenue
The current Board approved budget for IGT 2 is based on an original revenue estimate of $7.4 million, while actual revenue received was $8.7 million. Based upon discussion and direction provided at the August 27, 2014, Quality Assurance Committee, staff recommends allocating the additional $1.3 million for children's health and/or support of the safety net. For children's health services, priority could be given to addressing pediatric obesity and expanding access to children's health services. Safety net support could include, but not limited to, assisting safety net provider in their sustainability efforts.

Staff will present a proposed plan and recommendations for the additional funding allocation for Board consideration at a future meeting.

Plan for Wraparound Services
As discussed above, the Board-approved IGT 2 budget includes an allocation of $1.4 million for wraparound services and optional benefits for CalOptima members. The intent of these funds is to help address recognized gaps in services, as well as barriers to accessing preventive care and treatment.

The Board previously identified children's dental and vision services as priorities for this category of IGT funding, given the historically low utilization of these services. For example, only 54% of the nearly 190,000 Orange County children enrolled in Denti-Cal, which is administered directly by the state on a fee for service basis, had a dental visit in the previous year.[1] Similarly, only 52% of CalOptima's population under 19 years of age received a vision screening through a CalOptima provider in 2011. Lack of transportation; language barriers; inconvenient office hours; difficulty locating a provider that accepts Denti-Cal or Medi-Cal/Vision Services Plan (VSP); and parental beliefs regarding the timing of the first dental visit or vision screening are some reasons for the low utilization rates.

To help inform a funding plan to begin addressing these gaps, staff consulted with Kids Vision for Life, a non-profit dedicated to prevention of vision problems in children; Dr. Marc Lerner, Medical Officer, Center for Healthy Kids and Schools, Orange County Department of Education; and the

[1] "Why kids in Denti-Cal are feeling the pain," Children Now, 2013.

Children and Families Commission of Orange County, all of which have extensive expertise in these subjects, as well as deep knowledge regarding service gaps and access barriers affecting Orange County children.

At this time, staff recommends the Board consider expenditure of $900,000 for school-based children's dental and vision services, in amounts not to exceed $500,000 for vision services and $400,000 for dental. If approved, the recommended action will be accomplished in accordance with approved CalOptima Procurement Policy. Conditions for selection will include previous experience providing services at Orange County schools in high-need areas, as well as willingness to partner and coordinate with other providers for co-deployment of vision and dental services.

Children's Vision Services – $500,000

- Conduct school-based vision screening and assessment and supply eyeglasses to children with vision problems as medically recommended, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local vision care providers and conduct follow-up to encourage families to connect with these providers for their children's ongoing vision care.

Children's Dental Services – $400,000

- Conduct school-based dental screening, education and preventive care, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local dentists and conduct follow-up to encourage families to connect with these providers for their children's ongoing dental care.

If approved, staff anticipates selection of service providers, and inception of services, during the current (2014-15) school year. Moreover, staff will work with the selected vision and dental health partners to monitor and evaluate outcomes, and evaluation reports will be submitted to the Board's Quality Assurance Committee (QAC) for review. Upon completion of both programs, proof of concept data will be submitted to the Department of Health Care Services for its consideration of future reimbursement to providers of school-based vision and dental care.

As a separate but complementary effort, staff is also exploring opportunities to pilot incentives for pediatric primary care providers to provide basic oral health education and make timely referrals for dental care.

Another wraparound service being explored is pediatric obesity prevention and treatment. FY 2010-11 (IGT 1) funds were set aside for this purpose by prior Board action. However, given the complexity of this health issue and the dearth of effective models, staff brought this topic to the August meeting of the Board's QAC for discussion and direction. Dr. Candice Taylor Lucas, a noted expert on pediatric

obesity, provided guidelines and recommendations to the QAC. Based on input from this group, staff anticipates presenting funding recommendations for the Board's consideration in October.

Quality Assurance Committee Action
At its August meeting, the Board's Quality Assurance Committee approved the recommended Board of Directors approval of requested actions, but did not take action on proposed school-based services due to lack of consensus regarding whether schools are the most effective platform for children's vision and dental services, and whether IGT funds should be expended on these services.

Fiscal Impact
The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations
The final budget for IGT 2 incorporates additional funds received in a manner consistent with prior Board actions. Funding for vision and dental wraparound service was approved by prior Board action and will provide enhanced services to current CalOptima members not available through current covered benefits, a key requirement for the use of IGT funds. Proposed funding categories for IGT 3 allow for continued support of key organizational priorities and programs.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/29/2014*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. E. Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)

Contact
Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions
Approve grant awards in the aggregate amount of up to $200,000 to designated community health centers to support new and prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background
Through recent discussions with representatives of Orange County's community health centers, CalOptima learned that several health centers have an urgent need for specialized technical assistance to ensure successful attainment of, and transition to, Federally Qualified Health Center (FQHC) designation. FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima Medi-Cal members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites.

To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay. Prospective FQHCs often begin by applying to become a Non-grant-supported Health Center, more commonly known as an FQHC "look-alike." This interim designation confers many of the same benefits as full FQHC status, with the exception of the annual $650,000 grant that full FQHCs receive from the Health Resources and Services Administration (HRSA) to offset the cost of uncompensated care. Additional benefits of FQHC status are listed in the attachment to this item.

According to the Coalition of Orange County Community Health Centers, there are currently two look-alikes in the county; both are preparing to submit an application for full designation by the October 7th federal deadline. Existing FQHCs are also required to submit an application in order to expand to new sites; three Orange County FQHCs plan to apply for a New Access Points grant in October, with new sites planned for Tustin, Santa Ana and Lake Forest.

Prospective FQHCs, and those that wish to expand, must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal impact during the implementation period. In addition, newly-designated FQHCs derive long-term benefit from technical assistance with state and federal rate setting negotiations,

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which help ensure a sustainable business model. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Five (5) Orange County health centers are preparing to submit applications by the next federal deadline of October 7, 2014. Clinics will be notified of the application outcome no later than June 30, 2015, and most likely in the Spring. A total of eight (8) grant recipients are proposed. Of those, six (6) are prospective FQHCs, applicants for new access points, or "look-alikes" upgrading to full FQHC status, as follows:

1. VNCOC Southland Health Center: FQHC "look-alike" applying for full designation;
2. North Orange County Regional Health Foundation: "look-alike" applying for full designation;
3. Camino Health Center: Full FQHC applying for a new access point in Lake Forest;
4. Friends of Family Health Center: Full FQHC applying for a new access point in Tustin;
5. Share Our Selves (SOS): Full FQHC applying for a new access point in Santa Ana; and
6. La Amistad / Puente a la Salud: New applicant.

In addition, two other clinics that received FQHC designation in 2013, Nhan Hoa Comprehensive Health Care Clinic and Serve the People, are scheduled for HRSA site visits in late 2014, which they must pass in order to successfully complete the federal designation process.

At this time, staff recommends a grant to up to eight (8) community health centers for an individual allocation not to exceed $30,000 per organization and a total aggregate amount not to exceed $200,000. In approving the staff recommendation, the Board would be making a finding that the proposed expenditures are in the public good and consistent with CalOptima's statutory purpose. The proposed grants are to be used to assist new and prospective FQHCs with consulting costs, such as for rate negotiations and HRSA site visit preparation, but shall not be used for centers' administrative costs or staff time. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population. In addition, terms of the funding agreements will require a detailed scope of services and prior approval of all contracts and subcontractors utilized for the specialized technical assistance.

CalOptima is committed to working with community health centers to explore additional opportunities to support the safety net during this period of rapid change and increased demand in the healthcare sector, and will return to the Board with recommendations at a future meeting.

Fiscal Impact

The recommended action is consistent with the Board's previously approved IGT 2 allocation of $1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

FQHCs are vital to Orange County's safety net; the proposed support for new and prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
Benefits of FQHC Status

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

9/26/2014 — **Date**

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Benefits of Federally Qualified Health Center (FQHC) Designation

- Section 330 grant funds to offset the costs of uncompensated care and other key enabling services (Health Center Program grantees receive these grant funds. Look-alikes are eligible to compete for them.)
- Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (Look-alikes are not eligible for this benefit.)
- Prospective Payment System reimbursement for services to Medicaid patients
- Cost-based reimbursement for services to Medicare patients
- PHS Drug Pricing Discounts for pharmaceutical products under the 340B Program Federal loan guarantees for capital improvements (Look-alikes are not eligible for this benefit.)
- Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (CHIP) enrollment services
- Reimbursement by Medicare for "first dollar" of services because deductible is waived if FQHC is providing services
- Access to Vaccines for Children Program for uninsured children
- The National Health Service Corps (NHSC) can help health centers, look-alikes, and free clinics recruit and retain qualified providers who care about communities in need and choose to work where they are needed most.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. *Primary Care: The Health Center Program: Program Benefits*. Downloaded from http://bphc.hrsa.gov/about/benefits/.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. C. Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants

Contact
Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions
1. Authorize grant awards in the aggregate amount of up to $200,000 to eligible community health centers for Phase 2 of the Safety Net Program to support prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds; and
2. Approve $25,000 for an expert consultant to monitor grant recipients' performance and assess progress toward FQHC designation, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background
In October 2014, the CalOptima Board of Directors approved grant awards for specified new and prospective community health centers to address clinics' need for specialized technical assistance to attain, or transition to, Federally Qualified Health Center (FQHC) designation. A total of $200,000 in FY 2012-13 Intergovernmental Transfer (IGT 2) funds was approved for eight (8) centers for Phase I of this initiative.

For Phase 2 of CalOptima's safety net support initiative, staff proposes grant awards for clinics that are interested in applying for FQHC designation, but were not ready for the 2014 cycle and would benefit from funding support to assist with costs related to feasibility analysis; FQHC application development; and/or capital improvements to meet more stringent federal requirements (such as implementation of an electronic health record system or improvements to clinics' waiting rooms).

FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites. To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay.

Prospective FQHCs must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal

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impact during the implementation period. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Based on discussions with the Coalition of Orange County Community Health Centers, it is understood that at least three (3) Orange County health centers are interested in pursuing FQHC designation. Hence, for Phase 2 of CalOptima's safety net support initiative, staff recommends grant awards for up to four (4) community health centers for an individual allocation not to exceed $50,000 per organization, and a total aggregate amount not to exceed $200,000.

At this time, Sierra Health Center, Korean Community Services and Laguna Beach Clinic would be eligible for Phase 2 support. The final selection of health centers would be based upon a staff assessment of readiness and a commitment by the health center to undertake the necessary process for the grant award. However, community health centers currently included in Phase 1 would not be eligible for Phase 2 support.

The proposed grants are to be used to assist prospective FQHCs with consulting costs, such as for feasibility assessment and financial analysis, work plan development, and formulation of HRSA application, or for infrastructure or capital improvements that may be needed for readiness to submit a HRSA application. Funds shall not be used for general operating support. A key early deliverable for these grants will be a clinic self-assessment and written plan for moving toward FQHC designation. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population.

Staff also recommends that an additional $25,000 of IGT 2 funds be set aside for a consultant with expertise in FQHCs to assist CalOptima in monitoring grant recipients' performance toward grant objectives; assessing grantees' progress toward attainment of FQHC designation; and making recommendations for any needed future support to prospective FQHCs. Qualified consultants are currently conducting the work required for Phase I of the Safety Net FQHC support and staff would procure needed services from one or more of the current vendors consistent with CalOptima procurement policy.

In approving the staff recommendations, the Board would be making a finding that the proposed expenditures are in the public interest and consistent with CalOptima's statutory purpose.

Fiscal Impact

The recommended action is consistent with the Board's previously approved IGT 2 allocation of $1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations or expenditures.

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Rationale for Recommendation
FQHCs are vital to Orange County's safety net; the proposed support for prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature Date

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

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

Recommended Actions
1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background
At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion
Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

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CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VII. G. Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Action

Authorize the reallocation of OneCare PCC funds from Year 2 to Year 1 in order to compensate delegated OneCare Physician Medical Groups (PMGs) for the month of March 2015.

Background

At its March 6, 2014, meeting, the CalOptima Board of Directors (Board) approved the final expenditure plan for $12.4 million in Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) funds. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care setting. As part of this initiative CalOptima and PMGs would hire PCCs for up to two (2) years. Within the PMG, PCCs would serve as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare PMG contract amendments to provide funding to PMGs to hire and retain PCCs. The Board authorized the expenditure of FY 2010-11 IGT funds over a two-year period, with a total of up to $1.85 million expended in Year 1, and up to $1.95 million expended in Year 2 as authorized by the Board in March 2014.

Discussion

The Board authorized $1.85 million to fund PCCs in Year 1. However, due to a higher than expected retention of membership in OneCare, the funding allocation was depleted when the February 2015 PCC capitation payment was made to contracted OneCare PMGs.

Management requests that the Board approve a budget reallocation of approximately $200,000 from the $1.95 million budget allocation in Year 2 to make the March 2015 PCC capitation payment. Staff estimates that the remaining funding for the PCC program in Year 2, which was authorized through March 31, 2016, will be sufficient since OneCare members will transition to OneCare Connect in December 2015.

Fiscal Impact

The recommended action will reallocate $200,000 in FY 2010-11 IGT funds from Year 2 to Year 1, and is consistent with the expenditure plan previously approved by the Board on March 6, 2014. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

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Rationale for Recommendation
CalOptima staff recommends this action in support the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare Program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

3/27/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VII. H. Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve $3.6 million in Fiscal Year (FY) 2010-11 IGT funds for Complex Case Management for PCCs in the OneCare Connect Program, including for OCC members in the CalOptima Community Network:
    a. Allocate $1.15 million from 'PCC supplemental';
    b. Allocate $500,000 from 'General Contingency'; and
    c. Reallocate $1.95 million from "Strategies to Reduce Readmissions."

2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute OneCare Connect Health Network contracts that include funding to hire, train and retain PCCs for the period of July 1, 2015, through June 30, 2016.

3. Authorize CalOptima staff to hire, train and retain PCCs to support OneCare Connect members in the CalOptima Community Network during the July 1, 2015 through June 30, 2016 period.

Background

In actions taken at the January 3, 2013, February 7, 2013, and December 5, 2013, meetings, the CalOptima Board of Directors (Board) authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, also now known in the state as the Cal MediConnect Program and branded by CalOptima as OneCare Connect.

At its March 6, 2014, meeting, the Board authorized the expenditure of IGT funds to support the hiring of PCCs by both CalOptima and Physician Medical Groups (PMGs) for up to two (2) years to provide services to OneCare members. Within the PMG, PCCs would serve as a single point of contact for OneCare members and help members navigate the healthcare delivery system, facilitating access to care and services.

Subsequently, at the April 3, 2014, meeting, the Board authorized the CEO, with the assistance of legal counsel, to execute amendments to OneCare PMG contracts to include funding for hiring, training, and retention of PCCs. The Board approved funding for the PCCs at a rate of $14.53 per member per month (PMPM). PCC payments rates are further adjusted according to performance metrics established by CalOptima and described in a CalOptima PCC Policy and Procedure.

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Discussion

The Board has authorized the use of up to $3.8 million in FY 2010-11 IGT funds over a two-year period to hire PCCs to support the execution of the OneCare Model of Care by delegated PMGs. The creation of the position proved to be an integral part of the remediation of the OneCare audit findings. CMS found CalOptima's PCC Program to be a best practice among Medicare Advantage plans. The PCC program launch has exceeded expectations, and is an integral feature of the approved Model of Care for OneCare Connect, and is no longer an optional component.

Management recommends the Board to approve this action to effectuate the implementation of the successful PCC program for the Cal MediConnect Program, which CalOptima has branded as OneCare Connect. CalOptima would require OneCare Connect contracted Health Networks to hire and retain PCCs. The OneCare Connect contracts will stipulate the conditions for the funding of the PCC positions and will provide the parameters and expectations of the PCC program. Management is requesting $3.6 million in total FY 2010-11 IGT funds for PCCs for OneCare Connect Program from the following:

- Allocate $1.15 million from 'PCC supplemental';
- Allocate $500,000 from 'General Contingency'; and
- Reallocate $1.95 million from "Strategies to Reduce Readmissions."

Management requests funding the program with IGT funds for FY 2015-16, with additional funding subject to future Board approval and IGT fund availability. Funds will be used for the creation of the PCC position by the delegated health networks and the CalOptima Community Network in order to execute the OneCare Model of Care for OneCare Connect and provide ongoing funding of the PCC positions for the next year of the OneCare Connect program. After this time, CalOptima will evaluate if these positions will be self-funding following the first year based upon improved clinical outcomes and lower utilization costs. In addition, the PCCs will support preventive and chronic disease services that results in improvement in HEDIS scores and an anticipated improvement in OneCare Connect's quality rating. Finally, PCCs will improve data capture that support appropriate Hierarchical Condition Category (HCC) scores for OneCare Connect.

The PCC positions hired by CalOptima to serve OneCare Connect members in the CalOptima Community Network will be funded in the same manner as CalOptima's delegated Health Networks.

Fiscal Impact

The recommended action will result in the expenditure of IGT funds in FY 2015-16 of $3.6 million in FY 2010-11 IGT funds. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the expenditure of IGT funds as approved at the March 2014 Board Meeting. In addition, the PCCs are an integral component of the enhanced Model of Care that has been a successful program in OneCare and will an important component of the OneCare Connect Program that will expand CalOptima's ability to apply best practices in care coordination for CalOptima's members eligible for Medi-Cal and Medicare.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *3/27/2015*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize and direct the Board Chair to execute an amendment to the primary agreements among the California Department of Health Care Services (DHCS), the Regents of the University of California on behalf of the University of California, Irvine, and CalOptima for the purpose of securing an IGT for the upcoming Rate Year 2013-14 IGT (IGT 4); and
2. Approve modification in eligible uses for IGT 2 funds designated to support Federally Qualified Health Centers in Orange County.

Background

CalOptima began participating in the rate range IGT program for its rate year that began July 1, 2010. This IGT arrangement involves an approved government entity ("funding entity") providing non-federal funds to serve as a match to allow the State to draw down the difference between the highest and lowest actuarially approved Medi-Cal reimbursement rate from the Center for Medicare and Medicaid Services (CMS). Management's understanding is that rate range IGTs are currently in place in all managed care counties in California. Eligible funding entities include but are not limited to county governments, district hospitals, and UC hospitals. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives, which enhance care to Medi-Cal members.

CalOptima has partnered with the Regents of the University of California on behalf of UCI to secure three IGTs to date, and staff has started the process for a fourth proposed IGT for Rate Year 2013-14. This IGT arrangement involves UCI providing the non-federal funds for the rate increase to CalOptima and the administrative fee charged by DHCS. A high-level progress update for each of these IGTs is attached.

The CalOptima Board approves all proposed uses and authorizes the plan to participate in each available IGT. Per the State's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must finance improvements in services for Medi-Cal members. The approved uses are intended to generate a positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Presently, staff recommends one action related to the proposed IGT 4 transaction and one modification to a program funded by IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

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IGT	Rate Year	IGT Funds Received by CalOptima ($)
IGT 1	2010-2011	12.4M
IGT 2	2011-2012	8.7M
IGT 3	2012-2013	4.8M
IGT 4	2013-2014	5.5M (projected)

Discussion

IGT 4 Application

On April 24, 2015, CalOptima and UCI submitted a proposal to DHCS for a fourth IGT. If approved, the proposed IGT will result in revenue of approximately $5.5 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in or about September 2015. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 4 funding. Additionally, consistent with the proposal to DHCS submitted in April 2015, staff recommends two general categories of use for IGT 4 revenue as follows:

1. Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health, consistent with the Board's March 2015 approval of these five priority areas;
2. Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

Staff will develop a budget allocation for the proposed categories to be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the State. Staff will continue to gather information on whether there may be additional acceptable funding entities in Orange County with the capacity to partner to participate in future rate range transfer processes. The intent is to allow CalOptima to draw down maximum available rate range eligible funding to support Medi-Cal enrollees. For example, in the most recently proposed IGT 4, the State indicated that funding entities in Orange County could provide up to $28M as the non-federal source; UCI Health was able to provide $13.7M tied to uncompensated care rendered by UCI Physicians to CalOptima members. After factoring in the available federal match and required state fees, it is possible that CalOptima could have accessed an additional $11M in net revenue to support Medi-Cal members for this rate year.

Potential IGT 4 Funding Needs/Priorities

Health Homes

The Medicaid Health Home State Plan Option, under the Affordable Care Act (Section 2703), enables states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries

with chronic conditions, including homelessness and/or mental illness. California's Health Homes Program is intended to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. On April 20th, 2015, the DHCS indicated its intent to require participation from all counties effective 2016, with the benefit implemented through the managed care organizations who will then contract with community organizations. Staff is monitoring the development of final program regulations and will provide details on specific projects in the future as additional information becomes available.

1115 Waiver
California's existing Bridge to Reform 1115 Waiver expires on October 31, 2015. DHCS will seek approval of the new Waiver by November 2015 from CMS. At this time, the State's Waiver application proposes key delivery system transformations, including but not limited to changes for counties with public hospitals, regional incentives among managed care organizations, providers and counties behavioral health systems, workforce development initiatives, access to housing and supportive services, and whole person care pilots to improve and integrate physical and behavioral health. Staff will continue to monitor the development of final program regulations and will keep the Board apprised as new information becomes available.

As additional details become available, staff will return to the Board as appropriate with recommendations on the possible use of one-time IGT funded to launch potential early implementation projects to prepare for these critical programmatic changes.

Approve modification of IGT 2 funds designated to support Federally Qualified Health Centers (FQHC)
The Board approved $200,000 in funding in the *Strengthening the Safety Net* priority area at its October 2014 meeting. Specifically, the funding was designated to support engagements with qualified consultants/vendors to partner with up to eight named Orange County community clinics to support their conversion to FQHC status from FQHC "look-alike" status. To date, staff have received formal submissions from seven eligible clinics, with an additional application in progress. The ultimate goal was to contribute to a robust and sustainable system of care for vulnerable CalOptima members who access care at community clinics. Receipt of FQHC status will allow clinics to receive critical and stabilizing federal funds. A second cycle of funding (FQHC Phase 2) was designated for clinics in earlier stages of readiness to apply. The status of IGT-funded Safety Net projects is listed in the attachment.

At this time, staff recommends broadening eligible expenses to include permitting funding for one-time costs associated with merging with an existing FHQC or consulting costs associated with adding a critical new service that will facilitate greater access to care and a more robust reimbursement rate.

No funds will be used to support staff costs or recurring expenses. Currently, funds are designated for consulting services only. Specifically, staff has learned that one area clinic has elected to merge with an existing FQHC to achieve its sustainability goals. Effective May 2015, L'Amistad Health Center will be part of St. Jude Neighborhood Centers, which was not named as one of the eight clinics in the original Board approval. What is being proposed is a modification to enable St. Jude's to receive

support in lieu of L'Amistad. This funding will address the project management expense associated with bringing L'Amistad on to St. Jude Neighborhood Center existing electronic health record at a cost of $12,000, an expense within the maximum amount allowable for each clinic under the grant program. This modification is recommended as the expense is consistent with the Board's intent of accelerating sustainability and access. Likewise, a modification is recommended to enable clinics to allocate eligible consulting hours to prepare for a scope of service request in conjunction with preparation for new access point submission. This proposed change will provide an avenue for greater access to critical services such as dental or behavioral health in underserved communities.

Fiscal Impact

Fiscal Year (FY) 2013-14 IGT (IGT 4)
The recommended action to execute the FY 2013-14 IGT will provide approximately $5.5 million in one-time IGT revenue. Management will present an expenditure plan for Board approval at an upcoming meeting.

FY 2011-12 IGT (IGT 2)
The recommended action to permit St. Jude's to act as an eligible recipient under the Phase 1 FQHC program is budget neutral, as St. Jude's Neighborhood Clinic will replace L'Amistad as one of the eight eligible grantees. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations

Proposed funding categories for IGT 4 would allow for continued support of key organizational priorities and programs. Modification to IGT 2 is proposed to ensure broad participation from area community clinics in the FQHC grant cycle.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Presentation: IGT Progress Report

_____ _____

Authorized Signature **Date**

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Intergovernmental Transfers (IGT): Progress

Board of Directors Meeting
May 7, 2015

Lindsey Angelats
Director, Strategic Development

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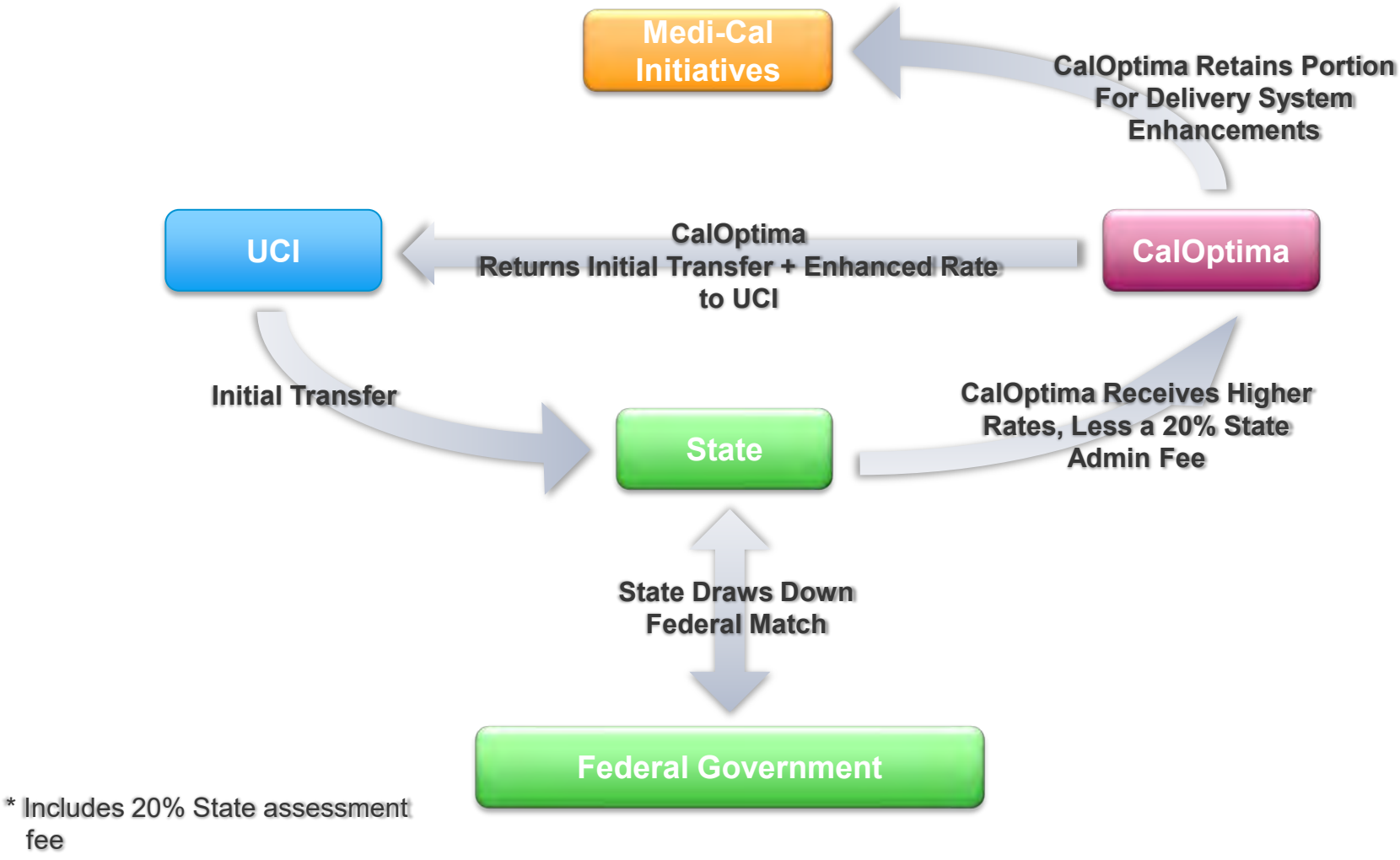
Overview of CalOptima/UC Irvine IGT



* Includes 20% State assessment fee

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CalOptima A Public Agency Better. Together.

IGTs Purpose and Restrictions

- Revenue generated through IGTs must be used to finance enhancements in services for Medi-Cal members
  - Support enhanced Medi-Cal program
  - Enable CalOptima to pay providers designated by the funding entity (UCI is currently the only funding entity used)

- Funds are potentially non-recurring, since there is no guarantee of future IGT agreements; funds are suited for one-time investments or as seed capital for new initiatives for members

- CalOptima is only plan allowed to retain funds. This process is consistent with state and federal rules and was approved by DHCS and CMS.

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount
IGT 1	12-13	$12.4 M
IGT 2	13-14	$8.7 M
IGT 3	14-15	$4.8 M
IGT 4	15-16*	(Est. $5.5 M)*
Total Funds Received		$25.9 M

* Transaction has received state and federal approval but funds have not been received yet.

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IGT Presentation Timeline

	May	June	July	Aug	Sept	Oct
Board		IGT 3 Budgeting; IGT 1-2 Progress Report				IGT 3 Budgeting; IGT 1-3 Progress Report
QAC	IGT 3 Budgeting				IGT 4 Budgeting	
FAC	IGT 3 Budgeting				IGT 4 Budgeting	

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact
Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions
1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose.

Background / Discussion
To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan
At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

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- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

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These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader *9/25/2015*
Authorized Signature **Date**

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IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

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IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

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Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

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IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

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Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents 23% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

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Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

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Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

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Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

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IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Phil Tsunoda, Executive Director Public Policy and Public Affairs (714) 246-8400

Recommended Actions

1. Extend the authorization of expenditures of Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) Funds (IGT 1) for OneCare Personal Care Coordinators (PCC) from April 1, 2016 through December 31, 2016; and

2. Authorize the reallocation of $50,000 in OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016, through December 31, 2016.

Background

At the March 6, 2014, meeting, CalOptima's Board of Directors approved the final expenditure plan for $12.4 million for IGT 1. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care settings. As part of this initiative, CalOptima and health networks would hire PCCs for up to two years. At the health network level, the PCC serves as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare health network PMG contract amendments to provide funding to health networks to hire and retain PCCs. The Board authorized the expenditure of IGT 1 funds over a two-year period, with a total of up to $1.85 million expended in Year 1, and up to $1.95 million expended in Year 2 as authorized by the Board in March 2014. The end date of the two-year authorization is March 31, 2016.

At the April 2, 2015, meeting, the Board authorized reallocation of $200,000 from the $1.95 million budget allocation in Year 2 to make the March 2015 OneCare PCC capitation payment.

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Discussion

On January 1, 2016, the majority of OneCare members were passively enrolled into the OneCare Connect program. However, not all OneCare members were eligible for this transition, and these members still remain in OneCare. As of January 2016, there were approximately 1,238 active OneCare members. In order to maintain similar practices for OneCare and OneCare Connect, so that OneCare members receive the same quality of care as OneCare Connect members, staff proposes to continue the PCC program for the remaining OneCare members through December 31, 2016.

Staff estimates the monthly expenditures for OneCare PCCs is approximately $20,000. As of January 31, 2016, $175,401 remains in IGT 1 funds for the OneCare PCC program. Assuming the same level of funding through the rest of the calendar year, the projected shortfall for the OneCare PCC capitation payments by December 31, 2016, will be approximately is $44,599. To cover this shortfall, Management recommends that the Board approve a budget reallocation of $50,000 from OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016 through December 31, 2016.

Fiscal Impact

The recommended actions to extend authorization of expenditures for the OneCare PCC program through December 31, 2016 and to reallocate $50,000 from the OneCare Connect PCC program to the OneCare PCC program is expected to have a neutral fiscal impact to CalOptima. Expenditure of IGT funds is limited to providing enhanced benefits to CalOptima Medi-Cal beneficiaries, and has been restricted to one-time purposes, and does not commit CalOptima to future funding or budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachments

None

/s/ Michael Schrader
Authorized Signature

02/26/2016
Date

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
14. Consider Extension of Deadline for Intergovernmental Transfer (IGT) Project with University of California, Irvine (UCI) Health's Observation Stay Pilot Program

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400
Dr. Richard Bock, Deputy Chief Medical Officer, (714) 246-8400

Recommended Action
Extend deadline for CalOptima and UCI Health to reach an agreement on project terms under IGT 4 for the UCI Health Observation Stay Pilot Program to December 31, 2017.

Background
For decades, hospitals and emergency departments (EDs) have faced the many challenges of overcrowding, overutilization, escalating health care costs and avoidable admissions. To address these issues, several hospitals have formed ED observation units (EDOUs) to care for patients with an expected length of stay (LOS) of less than 24 hours. The average LOS for admitted patients to the EDOU is typically 15–20 hours, whereas the average LOS for admitted inpatients is five days.

Observation units are clinical areas in the hospital or ED where patients are monitored for observation care. The Centers for Medicare & Medicaid Services (CMS) defines observation care as "a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the ED and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge."[1]

Third-party payers, such as Medicare, recognize the importance of observation services, or extended stays of up to 24 hours in EDs. They have created reimbursement strategies that appropriately compensate physicians and institutions for this care. However, some state Medicaid programs, including Medi-Cal and CalOptima, have not established clear guidelines for observation services. As a result, many patients are inappropriately admitted to hospitals in our region when they could have been better served with an efficient EDOU stay of less than 24 hours.

UCI Health established an EDOU program in June 2015 that has successfully treated more than 5,800 patients during a 17-month period (with more than 45% of these patients covered by CalOptima). Several studies, including some initiated by UCI's faculty, have highlighted the benefits of an organized EDOU program in emergency medicine with specific protocol-driven care. UCI Health currently tracks the protocol diagnosis, time, final disposition and care of patients who are admitted

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf

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to their EDOU on a monthly basis. Based on UCI Health's historical case data and growing use of EDOU protocols, leaders estimate that 180–200 CalOptima patients meet criteria for EDOU admission each month.

Discussion

At the December 1, 2016 CalOptima Board of Directors meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation stay pilot program at UCI Health for CalOptima Medi-Cal members, subject to the parties agreeing to program terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to December 31, 2017.

The funds will support a pilot project with UCI Health to test the cost-effectiveness of EDOUs and demonstrate the potential return on investment. This project will include tracking of specific CalOptima member information, including diagnosis, protocol, time in EDOU, discharge diagnosis, discharge status and readmission rates. UCI Health and CalOptima will conduct a monthly utilization review. If terms cannot be reached by December 31, 2017, staff will return to the Board with further recommendations.

Fiscal Impact

The recommended action has no fiscal impact on CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of operating "Better. Together.", CalOptima is committed to working with Orange County's provider and community partners to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

Concurrence

Gary Crockett, Chief Counsel

Attachment

None

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
13. Consider Appointment of CalOptima Board of Directors' Whole-Child Model Family Advisory Committee Chair and Vice Chair

Contact
Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Actions
Appoint the following individuals as Chair and Vice Chair of the Whole-Child Model Family Advisory Committee (WCM-FAC) for a term beginning December 7, 2018 through June 30, 2019:
1. Maura Byron as WCM-FAC Chair; and
2. Pamela Patterson, WCM-FAC Vice Chair.

Background/Discussion
Senate Bill 586 (SB 586) was signed into law on September 25, 2016 and authorized the establishment of the Whole-Child Model incorporating California Children's Services (CCS) covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Board of Directors established the Whole-Child Model Family Advisory Committee (WCM-FAC) by resolution on November 2, 2017 to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The WCM FAC is comprised of eleven voting members with nine family members and two community seats.

While CalOptima's Whole-Child Model program implementation start date has been pushed back, staff recommends that the Board make these appointments and that the WCM-FAC continue to meet to discuss this important program transition.

At their Special meeting on November 8, 2018, the Committee voted to recommended Maura Byron as Chair and Pamela Patterson as Vice Chair.

Chair
Maura Byron*
Pamela Patterson

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

*Indicates WCM FAC recommendation

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

Vice Chair
Pamela Patterson*

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

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The WCM-FAC recommends appointing a Chair and Vice Chair to provide support and continuity to upcoming meetings.

Concurrence
Whole-Child Model Family Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

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

11/28/2018 — **Date**

*Indicates WCM FAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
14. Consider Ratification of Expenditures Related to Emergency Repairs for CalOptima Facilities and Approval of Future Expenditures for Acquisition of Audio-Visual Equipment

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

Recommended Actions
1. Ratify unbudgeted expenditures from existing reserves for emergency purchases and repairs at CalOptima facilities located at 505 City Parkway West in Orange (505 Building) in the amount of $47,975.00, and 13300 Garden Grove Boulevard in Garden Grove (PACE Center) in the amount of $5,023.55; and
2. Authorize future unbudgeted expenditures of $21,977 from existing reserves for replacement audio-visual equipment at 505 City Parkway West in Orange.

Background
CalOptima owns a 10-story commercial office building located at 505 City Parkway West in Orange, with all floors occupied by CalOptima. In addition, CalOptima leases a one-story tilt up concrete building located at 13300 Garden Grove Boulevard in Garden Grove which is the location of the CalOptima PACE Center. Pursuant to the repair and maintenance section of CalOptima's lease, the landlord is only responsible for structural repairs to the PACE Center. CalOptima is responsible to ensure that both facilities are secure, clean and fully operational in order to safely accommodate the needs of employees, members, and other visitors.

Discussion

Emergency Purchases
Staff recommends the Board ratify and approve unbudgeted expenditures for the following emergency repairs:

- In November 2018, the 505 Building experienced a failure with the in-house security cameras that monitor the entire CalOptima office tower. CalOptima's contracted vendor rebooted the system; however, the security camera system failed, and numerous security cameras were rendered inoperable. On November 14, 2018, utilizing a bid exception, staff made an emergency purchase of $47,975 through CalOptima's currently contracted vendor to repair the security camera system. CalOptima contracted with the same vendor to ensure continuity of service, compatibility with existing equipment, maintenance of visual surveillance of all common areas within the building, and the protection and security of CalOptima's building, its employees, members and guests, and to avoid loss of human life or property. CalOptima's contracted vendor installed two (2) new servers, programmed and connected existing cameras to the new servers, provided sixty-two (62) new camera licenses, and upgraded the entire system's software.

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- In November 2018, CalOptima's contracted vendor adjusted the mechanical settings for the entry gate operations at the PACE Center; however, the gate's open/close mechanism failed in the open position. On November 15, 2018, utilizing a bid exception, staff made an emergency purchase of $5,023.55 for repairs to the entry gate at the PACE Center in order to ensure that the entry gate can fully close for full security of the PACE Center. CalOptima's contracted vendor replaced 46 feet of steel track, installed two (2) four (4) inch steel wheels on a new concrete track, and re-anchored the gate operator device. CalOptima contracted with the same vendor to ensure continuity of service and compatibility with existing equipment. It was necessary to make this emergency purchase to prevent trespassing and loss of property, in addition to ensuring the protection of CalOptima's leased building, its employees, PACE participants, and guests.

The emergency purchases with both contracted vendors were completed with emergency bidding exceptions in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy.

Replacement of Audio/Visual Equipment
Over a period of three (3) weeks in October and November 2018, projectors in Conference Rooms 107 and 108 at the 505 Building experienced three (3) failures. CalOptima's contracted vendor surveyed the projectors to see if they could be repaired. After detailed testing of the units, the contracted vendor determined the projectors could not be repaired or salvaged. Staff recommends that the Board authorize an unbudgeted amount totaling $21,977 from existing reserves to purchase projectors to replace the irreparable audio-visual equipment and restore full audio-visual operations in the conference rooms.

Fiscal Impact
The recommended action to authorize expenditures for emergency purchases at the 505 Building and the PACE Center and replacement of the conference room audio-visual equipment are unbudgeted items. An allocation of up to $74,975.55 from existing reserves will fund this action.

Rationale for Recommendation
Staff recommends approval of the recommended actions to protect the properties and assets of CalOptima and to keep them fully functional and operational in accordance with State and Federal guidelines. Authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and a safe and sanitary environment for our members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/28/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

15. Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Inter Governmental Transfer (IGT) 5 Funds

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400
Cheryl Meronk, Director, Strategic Development (714) 246-8400

Recommended Action

1. Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved Intergovernmental Transfer (IGT) 5 Adult and Children Mental Health priority area;
2. Authorize the CEO, with the assistance of Legal Counsel, to enter into a contract with the County of Orange Health Care Agency, or a three-way agreement with the Orange County Health Care Agency and Mind OC, including indemnification, defense and hold harmless provisions by the County of Orange and also by Mind OC (if three-way agreement), in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services provided to CalOptima Medi-Cal members at the Be Well Wellness Hub to commence once the Hub is operational.

Background

IGTs must meet state and federal requirements and must be approved by the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS).
Funding agreements provide that provider recipients will use their share of IGT-funded capitation rate increases for the provision of health care services to CalOptima Medi-Cal members. Similarly, where CalOptima retains portions of IGT-funded capitation increases, such funds are designated for health care services and administrative purposes that improve quality, access and efficiency in the Medi-Cal program for the benefit of CalOptima Medi-Cal members.

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in remaining IGT 5 funds. The funding categories included in DHCS-approved IGT 5 included:

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health; and
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver Initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

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- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

Discussion

Be Well OC Regional Wellness Hub

The County of Orange and numerous other local public agencies, hospital systems, non-profit organizations, faith-based organizations and other community stakeholders have been meeting to discuss the mental health care system in Orange County. This group of stakeholders, known as the Orange County Coalition for Behavioral Health (the Coalition), now formally known as Be Well OC, came together to promote, facilitate and support existing mental health services and identify gaps in care that exist across the County. In addition, the Coalition formed a non-profit entity, Mind OC, to develop financial resources to support the goal of creating a high-quality behavioral health system of care.

While CalOptima Medi-Cal members are each assigned a primary care provider and a health network that are responsible for meeting member health care needs, results from the MHNA suggest that as many as 40% of CalOptima members may not know who to call or where to go for mental health services. In addition, Orange County hospital data indicates that more than 50% of Emergency Department (ED) visits for mental health and substance use disorder (SUD) issues involve Medi-Cal members[1]. The costs for these ED visits fall on CalOptima and its delegated health networks. The ED environment is often counter-indicated for the treatment of mental health and SUD. In certain situations, the ED may exacerbate the condition, potentially leading to longer stays and increasing the likelihood of an inpatient admission to a hospital-based psychiatric facility.

The Regional Wellness Hub (Hub), which is currently in its initial stages of development, will provide enhanced services for CalOptima's Medi-Cal members by integrating and co-locating CalOptima and County of Orange mental health and substance abuse services, and community-based social support services in a central, easily accessible location that improves access, addresses whole-person care, improves outcomes, and reduce recidivism. The goal is to redirect a meaningful percentage of mental health patients from the ED to the more appropriate care setting of a Regional Wellness Hub. Staff's understanding is that the County of Orange acquired 265 Anita Street in March of 2018 for the amount of $7.8 million and Be Well OC has provided additional financial resources to develop project plans and cost estimations.

Based on these factors, the CalOptima Board of Directors IGT 5 Ad Hoc Committee comprised of Supervisor Do and Director DiLuigi, recommends that CalOptima commit up to $11.4 million for the Be

[1] 2016 Office of Statewide Health Planning and Development (OSHPD)

Well OC Regional Wellness Hub, to be drawn from IGT 5 funds, consistent with DHCS-approved uses, to address the behavioral health needs of CalOptima members that are not carved out of CalOptima's State Contract.

Advance Funding Requirements

Operational details and services to be offered at the Hub have been developed including the go-live date, specific scope of mental health and other services; some other key considerations still need to be finalized. In addition, the volume of CalOptima members who will use the Hub is uncertain at this time and it is unknown how long it will take for services to meet the advance funding amount. As proposed, funds are being provided prior to commencement of services at the Hub, such that the County of Orange and Mind OC may end up using these funds for facility development, construction and/or other start-up costs, subject to the obligation to provide CalOptima Medi-Cal members services once the Hub is up and running. Given the uncertainty of these factors and CalOptima's advance funding, CalOptima will include indemnification, defense and hold harmless provisions to provide that the IGT 5 funds are returned if the Regional Wellness Hub project does not go forward, does not ultimately deliver mental health services that benefit CalOptima Medi-Cal members, or the use of the funds for the Hub by the County of Orange or Mind OC is challenged and/or recovered by any regulatory agency.

The up to $11.4 million advance funding for services to CalOptima Medi-Cal beneficiaries will be based on the following requirements:

- Services prepayment funding is contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete construction of the first Wellness Hub, and that CalOptima's prepayment for services funding will be up to $11.4 million or one-third of the costs of development of the Wellness Hub, whichever is less;
- Commencement of development of the Wellness Hub by July 2020 and provision of agreed upon services to CalOptima Medi-Cal members no later than July 2021 based on Be Well's proposed construction schedule plus over an additional year for any potential delay;
- The Wellness Hub is to provide mental health and other related services to CalOptima Medi-Cal members at no additional cost to the members for the greater of five years or until the funding amount is exhausted (services provided to CalOptima Medi-Cal to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed upon methodology). Service areas may include the following:
    - Triage
    - Psychiatric intake and referral
    - Substance use disorder intake and referral
    - Residential treatment services
    - An integrated support center providing community and faith-based services
- Services provided to CalOptima members (and charged to the CalOptima funding amount pursuant to this proposed arrangement) do not include mental health services (e.g., Specialty Mental Health Services) that are carved out of CalOptima's State Contract and are the financial responsibility of the County of Orange Health Care Agency (OCHCA) or Social Services Agency;
- The Wellness Hub must accept all CalOptima Medi-Cal members whose condition is appropriate for the facility; and

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- The parties will agree upon specific services as part of a contract (between CalOptima, County of Orange, and Mind OC, as appropriate), ensuring OCHCA will oversee all Wellness Hub operations and services, and ensure CalOptima Medi-Cal members access to the agreed upon services. The contract must be approved by the CalOptima Board prior to funds being disbursed.

The Orange County Board of Supervisors and Be Well OC will finalize operational and program plans in early 2019. The CalOptima Board of Directors will be provided with an update at that time.

Fiscal Impact

The recommended action to approve a contract of up to $11.4 million from IGT 5 to the Orange County Health Care Agency, or the Orange County Health Care Agency and Mind OC in exchange for mental health services for CalOptima Medi-Cal members has no fiscal impact on CalOptima's operations budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Be Well OC Regional Wellness Hub
2. Be Well Orange County 265 Anita St. Proposal

/s/ Michael Schrader — *11/28/2018*
Authorized Signature — **Date**

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Be Well OC Regional Wellness Hub

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

Mental Health in Orange County

- CalOptima's Member Health Needs Assessment highlighted Mental Health as a priority need in the community
  - Providers identified mental/behavioral health as one of the most important health problems facing Medi-Cal beneficiaries
  - Lack of knowledge and fear of stigma are key barriers to receiving mental health services
    - Approximately 1 in 4 CalOptima members who needed mental health services did not see a mental health specialist
      - Members did not know who to call or how to ask for help
      - Members did not feel comfortable talking about personal problems

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Be Well OC Regional Wellness Hub

- CalOptima is participating in Be Well OC, a collaborative initiative to make improvements to the mental health system of care in Orange County
- Be Well initiative includes creation of Regional Wellness Hubs
- Services available at the Wellness Hubs are expected to include (but may not be limited to):
  - Variety of mental health services
  - Substance Use Disorder treatment programs
  - Integrated support services linking community and social services
- Services available to any OC resident
  - Access based on clinical need

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Wellness Hub Services May Include:

- Triage
- Psychiatric intake and referral
- Substance use disorder intake and referral
- Residential treatment services
- Integrated support services center
  - Mobile crisis response team
  - Transportation
  - Social and community-based services
  - Faith-based organizations
  - Education, employment and legal services

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Be Well OC Regional Wellness Hub

- Benefits for CalOptima members
  - Centralized and accessible services
  - Whole person approach to address needs and coordination of care
  - Co-location of community-based social support services
  - Improved health outcomes and reduction in recidivism

- Estimates are that more than 50% of local Emergency Department visits for mental health and substance use disorder issues are CalOptima members

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Anita St. Wellness Hub

- OCHCA 2016 Strategic Financial Plan includes a priority to develop an integrated behavioral health services campus
  - 44,600-square-foot building purchased at 265 Anita St. in Orange
- Planning for the facility evolved in parallel with Be Well OC Blueprint
  - 60,000-square-foot new construction planned in partnership with Be Well
- Initial project cost estimate: $34.2 million

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Wellness Hub Funding Deliverables

- Up to $11.4 million funding contract for services to CalOptima members conditioned on the following:
  - Funding contingent upon receiving written attestation that Mind OC has obtained the balance of funds required to complete development of the first Wellness Hub
  - Construction of Wellness Hub to start no later than July 2020
  - Grand opening of Wellness Hub with full range of agreed upon services available to CalOptima members no later than July 2021
  - Wellness Hub must include agreed upon services at no cost to CalOptima or the member
  - Wellness Hub must accept all CalOptima members for first five years of operation until the funding amount is exhausted
    - Services provided to CalOptima Medi-Cal members to be valued at the Medi-Cal Fee-for-Service equivalent cost for such services or other comparable agreed-upon methodology
  - MindOC to enter into a three-way contract with OCHCA and CalOptima

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Recommended Actions

- Approve allocation of up to $11.4 million for Be Well Wellness Hub services to CalOptima Medi-Cal members from Board-approved IGT 5 Adult and Children Mental Health priority area;
- Authorize a contract with County and Mind OC (including indemnity provisions) in an amount not to exceed $11.4 million, in exchange for at least five years of enhanced services for CalOptima Medi-Cal members at the Be Well Wellness Hub.

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Be Well

ORANGE COUNTY

265 ANITA ST. PROPOSAL

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Vision: Be Well Orange County will lead the nation in optimal mental health[1] and wellness for all residents.

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[1]In the following document, the terms mental health and wellness encompass substance dependence and abuse.

A community in action.

Families across Orange County are suffering in the face of increasing mental health and substance use disorders. For many families, these challenges have become devastating catastrophes. If you are a resident of the Orange County community today, you undoubtedly have your own story – direct or indirect – to underscore this unfortunate reality.

265 Anita in the city of Orange is the first manifestation of Systems Change in Orange County. It is the place where we begin to build a new reality for this community, where together in public-private partnership we boldly impact individual, systemic and societal conditions so that all residents can Be Well.

265 Anita is a best-in-class regional treatment and wellness hub. It is a symbol of the strength and possibilities created when public and private partners strive together.

Orange County needs and deserves more than a new services building. **Let's build a beacon.**

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Executive Summary

Background

265 Anita St.

The Orange County HCA 2016 Strategic Financial Plan identified as a priority the creation of a campus-like setting for co-location of behavioral health services. In order to meet this need, HCA worked in collaboration with Orange County CEO/ Real Estate to purchase 265 Anita St. in the city of Orange. The 2.1 acre property hosts a 44,556 sq. ft. freestanding, two-story, stucco and glass office building with a landscaped, open-air atrium.

The HCA program planning process for the Anita St. building evolved in parallel with the public-private co-creation of the Be Well OC Blueprint (described in further detail in this section). Within that context, an opportunity emerged for a public-private partnership, between HCA and Mind OC (a not-for-profit organization described in further detail in this section), to design and develop a 60,000 sq. ft. building de novo, for the purpose of providing mental health and substance use disorder (SUD) services for all residents of Orange County regardless of payer.

Proposed here is the recommended plan to leverage public-private collaboration and actualize the full potential of 265 Anita St. as the county's first Be Well OC Regional Mental Health and Wellness Hub.

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Opportunity

In Process

As the first Regional Wellness Hub, 265 Anita will be a trusted beacon for the Orange County community. To optimize this opportunity, HCA can leverage Mind OC's private sector expertise in real estate development and healthcare facility design to benefit from past learning and efficiencies in planning, project management and construction. Three primary advantages to this approach include:

- speed to market
- cost
- quality

With HCA's approval and collaboration, an exploration of this approach is underway. The contents of this proposal are the result of that work to date. The following pages include a target population assessment, program and services descriptions, design and construction options, financing recommendations, and additional operational considerations. Notably, the 265 Anita clinical program proposed here is comprised of multiple services identified to meet specific community needs as reflected in both county and hospital data. The clinical program and operational facility design have been co-created by the clinical leaders of the HCA and Mind OC.

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Executive Summary

Context

Be Well OC Blueprint

Co-created by a variety of public and private stakeholders across the county, a branded Be Well OC Blueprint clearly articulates the steps needed to actualize the Be Well OC vision. Success starts with acceptance that the mental health sector alone cannot solve this pervasive healthcare challenge. Neither can the public or private sectors sufficiently address the complexities alone. Be Well OC brings together a robust, community-based, cross-sector strategy – public, private, academic, faith and others – to positively impact those challenges that diminish mental health and well-being.

Be Well OC harnesses a best practice model known as Collective Impact, with a clearly defined leadership structure, to advance: education and prevention of mental illness, reduction of stigma, promotion of mental health, early identification of problems, and comprehensive, coordinated treatment. Be Well OC will establish a community-wide, coordinated ecosystem of optimal mental health support and services.

Mind OC

Mind OC is a community-owned, not-for-profit, 501(c)3 created to support the advancement of Be Well OC and the Orange County mental health and wellness ecosystem. The Mind OC governance board is comprised of a cross-sector, multidisciplinary team of Orange County leaders. The team sets goals, develops strategy and deploys plans through focused work streams and specialized project workgroups, managing the cross-functional alignment of these efforts. Accountabilities include oversight and management of work streams and projects, ensuring adequate information, resources and support are provided, and serving as liaison to key stakeholders. Mind OC has three primary areas of focus:

1. Mental health and wellness infrastructure development
2. Value optimization and transparency in mental health and SUD services
3. Be Well OC sustainability and public/private partnerships

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Regional Hubs

As a foundational component of the Blueprint, and essential to effective services coordination, three regional anchoring Wellness Hubs are required to support the Be Well mental health system of care. The Wellness Hubs will include a variety of mental health and SUD treatment programs and are uniquely available to all residents of Orange County, regardless of payer. Access is based on clinical need.

The Wellness Hubs will be intentionally located and designed in synergistic compliment with the Homeless System of Care, and the goals of each respective Service Planning Area (SPA). It is critical to note the three Wellness Hubs are not designed exclusively to serve the OC homeless population. Hubs will have sufficient service and staffing capacity to address a range of mental health and wellness levels of risk and complexity. Each Hub will also integrate support services providing necessary linkage with myriad complimentary community and social services.

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Community Need

OC Emergency Department Volume, 2016 OSHPD

DIAGNOSES	Total OC Market	5 Mile Radius of 265 Anita	% of Total
Alcohol-related disorders	10,645	2,773	26.1%
Substance-related disorders	6,388	1,984	31.1%
Mood disorders	5,695	1,890	33.2%
Suicide and intentional self-inflicted injury	4,498	1,306	29.0%
Schizophrenia and other psychotic disorders	4,067	1,477	36.3%
Delirium dementia and amnestic and other cognitive disorders	960	285	29.7%
Miscellaneous mental health disorders	888	322	36.3%
Attention-deficit conduct and disruptive behavior disorders	484	174	35 9%
Screening and history of mental health and substance abuse codes	252	66	26.4%
Personality disorders	105	41	39.0%
Totals:	**34,024**	**10,336**	**30.4%**

Payer Mix	5 Mile Radius Payer Mix %	Total OC Market	5 Mile Radius of 265 Anita
Medi-Cal	52.9%	15,441	5,463
Commericial	23.0%	10,772	2,379
Self Pay	11.4%	3,823	1,176
Medicare	11.3%	3,464	1,172
Other	1.4%	525	147
Totals:	**100.0%**	**34,024**	**10,336**

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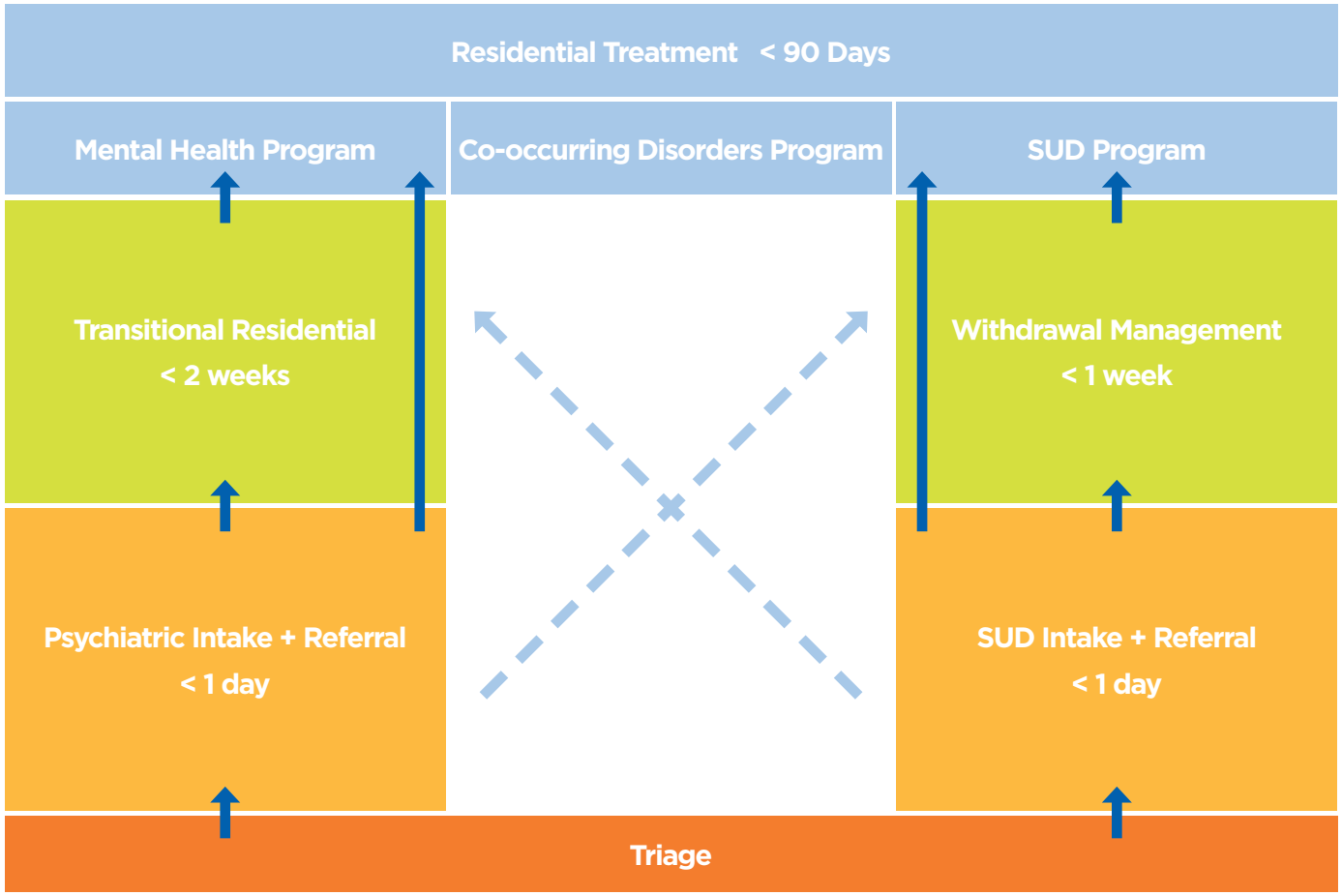
Proposed Program

The sum is greater than the parts. Integration of mental health and substance abuse services in a central, easily accessible location improves access. Coordination in care and operational synergy among services improves experience for patients and providers. Co-locating community-based social support services honors whole-person needs and a whole-systems approach, improves outcomes and reduces recidivism.



Integrated Support Services:

- Mobile Crisis Response Teams
- Transportation
- Social Services Support
- Community Based Organizations
- Faith Based Organizations
- Supportive Employment
- Supportive Education
- Legal Aid Services

*See Appendix for Program Access Projections and Discharge Planning.

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Proposed Services

There are seven different service elements that make-up the program at this first Be Well Regional Hub. OCHCA will hold the contracts with the various organizations providing the clinical services. The contracted providers will be required to contract with commercial health plans to ensure access to all members of the community regardless of the payer. Revenue from commercial health plans to the service provider will be applied to the cost reimbursement funds they are paid, lowering HCA's cost burden.

Program	Description	Length of Stay
Triage	**Target population:** Adults and adolescents are separated in this receiving area for walk-in/drop-offs to the campus. Screening is completed to determine clinical fit for the onsite programs. If onsite services are not appropriate for the need, a referral and transportation are provided.	**N/A**
Psychiatric Intake + Referral	**Target population:** Walk-in/drop off services for adults and adolescents with acute behavioral health challenges, who are at risk of hospitalization and present on a voluntary or involuntary basis. Services include: basic medical and medication services, psychiatric and psychosocial evaluation, crisis intervention, therapeutic support, education, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Substance Use Disorder (SUD) Intake/Referral	**Target Population:** Walk-in/drop-off services for adults under the influence of drugs and alcohol. Services include: voluntary screening, assessment, physical safety and monitoring, and linkage to the clinically indicated level of continuing care.	**< 1 day**
Withdrawal Management	**Target Population:** Individuals who can safely withdrawal from alcohol and/or other drugs in a safe and supportive community/residential environment. Services include: counseling, withdrawal monitoring and support.	**< 1 week**
Transitional Residential	**Target Population:** Adults in psychiatric decline requiring longer term stabilization to ensure safe transition. Services include: on-going assessment, psychiatric medication management, individual and group intervention, substance abuse education and treatment, and family and significant-other involvement.	**< 2 weeks**
Residential Treatment	**Target Population:** Persons living with Serious Mental Illness and co-occurring SUD. Specialized residential treatment services include: assessment, individual and group counseling, monitoring psychiatric medications, substance abuse education and treatment, and family and significant-other involvement.	**< 90 days**
Integrated Support Center	Through the expansion of the existing footprint of the building, additional services have been identified that function synergistically in support of the above programs. These include: • Mobile Crisis Response Team • Transportation • Social Services • Community Based Organizations • Faith Based Organizations • Supportive Employment • Supportive Education • Legal Aid Services	**N/A**

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Financing Model

Syndicated Prorata Share

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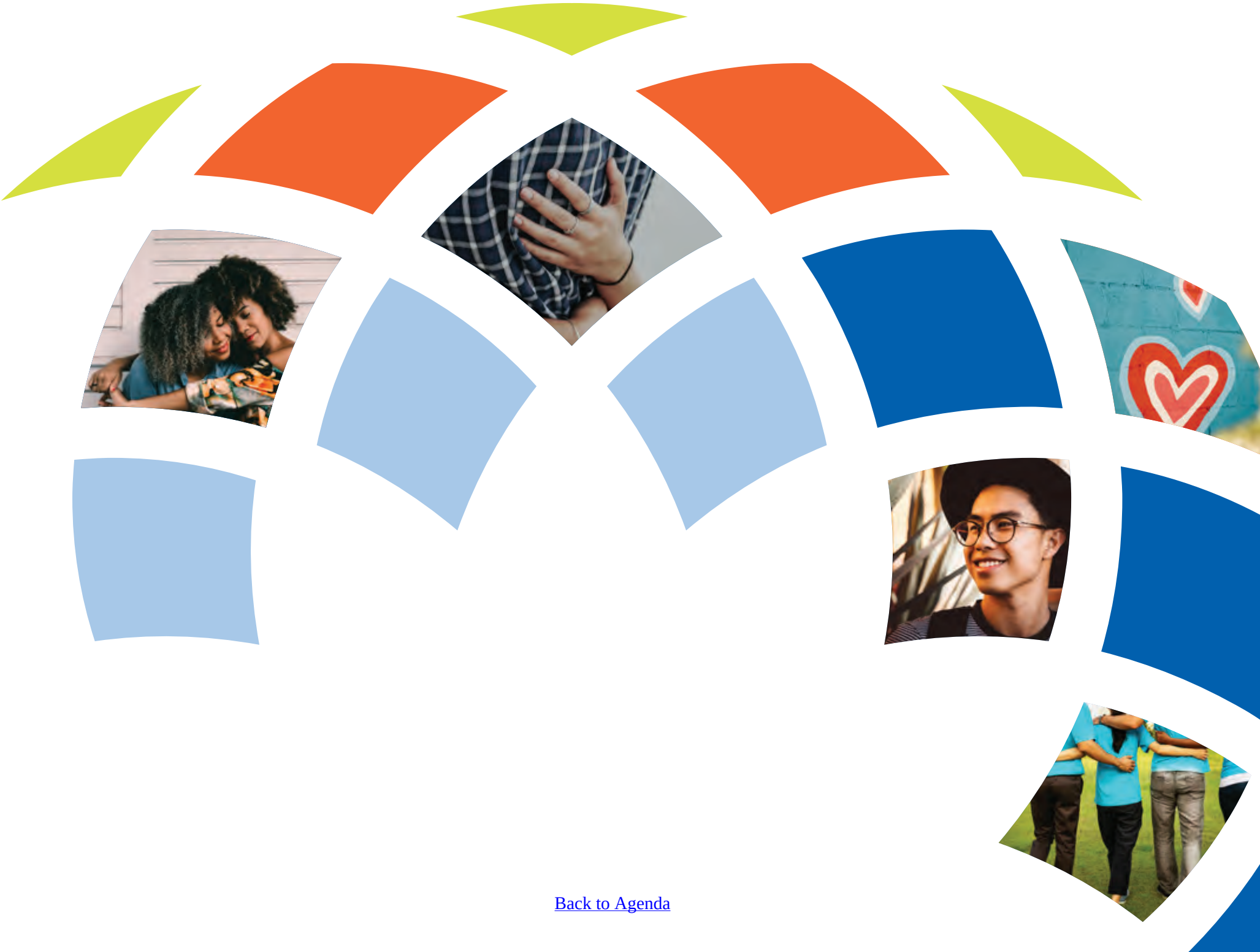

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

16. Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize the release of Requests for Proposal (RFPs) for community grants with staff returning at a future Board meeting with recommendations for award decisions; and
2. Authorize the reallocation of IGT 2 funds remaining from the Autism Screening project to Community Grants consistent with the state-approved IGT 2 approved funding categories.

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of IGT 5 funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to address the unmet needs identified by the MHNA.

At the February 2018 Board of Directors meeting, staff presented the Executive Summary of the MHNA as well as categories of needs in the community identified by the MHNA. The Board-approved categories included:

- Adult Mental Health
- Older Adult Mental Health
- Children's Mental Health
- Nutrition Education and Physical Activity
- Children's Dental Services
- Medi-Cal Benefits Education and Outreach
- Primary Care Access and Social Determinants of Health
- Adult Dental Services

After the June 7, 2018 Board of Directors meeting, CalOptima released a notice for Requests for Information (RFI) from organizations to better define the scopes of work to address community needs in one or more of the above referenced categories. CalOptima received a total of 93 RFI responses from community-based organizations, hospitals, county agencies and other community interests. The 93 RFI responses are listed as follows:

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MHNA Categories	# of RFIs
Adult Mental Health	15
Older Adult Mental Health	13
Children's Mental Health	13
Nutrition Education and Physical Activity	12
Children's Dental Services	5
Medi-Cal Benefits Education and Outreach	10
Primary Care Access and Social Determinants of Health	19
Adult Dental Services	6
TOTAL	93

Subject matter experts and grant administrative staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The Ad Hoc Committee, comprised of Supervisor Do and Director DiLuigi, met on November 9, 2018 to discuss the results of the 93 RFI responses for the MHNA categories and review the staff-recommended RFPs for consideration.

Following the review of the RFI responses, the staff evaluation process and recommendations, the Ad Hoc committee recommended moving forward with the following Community Grant categories:

Community Grant Requests for Proposal (RFPs)

Grant RFP	Total Grant Award
1. Access to Children's Dental Services	$1,000,000
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1,400,000
3. Access to Adult Dental Services	$1,000,000
TOTAL	**$3,400,000**

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Staff is also recommending the reallocation of an amount up to $400,000 remaining from the IGT 2 Autism Screening Project to support these community grants. This provider incentive project aimed at increasing the access to autism screenings for CalOptima children members has been discontinued. The program was able to screen a total of 110 children. Support of the grant RFPs fulfills the original Board-approved uses of the IGT 2 funds which were as follows:

1. Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
2. Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventive dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventive health programs.

Funding for the above grant RFPs is derived as follows:

- **$3.0 million**: Remaining from IGT 5 (following anticipated Board action related to other IGT 5 funds)
- **$0.4 million:** Reallocation from IGT 2 Autism Screening Project
- **$3.4 million:** Total available for distribution through Community Grants

Following receipt and review of the RFP responses, evaluation committees consisting of staff and other subject matter experts will evaluate the responses based on a standardized scoring matrix, and will return to the Board with recommendations and proposed funding allocations.

Fiscal Impact

Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations. The recommended action to authorize the release of the Requests for Proposal (RFPs) for community grants has no additional fiscal impact to CalOptima.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachment

PowerPoint Presentation: Community Grant RFP Recommendations

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

11/28/2018 — **Date**

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Community Grant RFP Recommendations

Board of Directors Meeting
December 6, 2018

Cheryl Meronk
Director, Strategic Development

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IGT 5 Process Summary to Date

Board authorizes Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identifies categories for community grants

Board authorizes Requests for Information (RFIs) to better define the scopes of work in each of the categories

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board Ad Hoc committee meets to consider recommending that the full Board authorize RFPs

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IGT 5 Expenditure Process

- Subject matter experts and grant administrative staff evaluated/scored all 93 RFI responses by category
  - Evaluation committees met July 30–August 9
  - Provided recommendations on scopes of work to be developed into RFPs

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

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Grant Funding

- **$14.4M** CalOptima's share of IGT 5
- **-$11.4M** Recommended grant to Be Well OC for first Wellness Hub
- **$ 3.0M** Remaining for recommended distribution for Community Grants
- **$ 400K** Re-allocation from IGT 2 Autism Screening Project
- **$ 3.4M** **Total Available for Community Grants**

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Three Recommended Grant RFPs

RFP #	RFP Description	Funding Amount
1	Access to Children's Dental Services	$1 million
2	Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	$1.4 million
3	Adult Dental Services	$1 million
	Total	**$3.4 million**

* Multiple awardees may be selected per RFP

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RFP 1

Access to Children's Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
  - Assist children/families with establishing a dental home close to their home for emergency and regular dental care
  - Provide or partner with other community dental providers to ensure patients receive restorative and other specialty dental services in addition to exams and screenings as needed

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RFP 2

Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)

- **Funding Amount:** $1.4 million
- **Description:**
  - Establish and/or operate school-based wellness centers where family, staff and community partners collaborate to align resources
  - Partner with health clinics that allow for school referrals and follow-up care
  - Provide health assessment/screenings on school campuses and community-based education for families

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RFP 3

Adult Dental Services and Outreach

- **Funding Amount:** $1 million
- **Description:**
  - Expand availability of dental services/treatment at health centers and/or mobile units with medical care integration for comprehensive health care
  - Ensure provider/staff capacity to perform assessment and restorative dental services
  - Expand dental services to nontraditional evening and weekend hours
  - Establish collaboration with community clinics/resources for specialized dental care

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Next Steps*

Mid-December 2018: CalOptima releases Community Grant RFPs, if approved

January 2019: RFP responses due

March 2019: Ad Hoc reviews recommended grant awards

April 2019: Board considers approval of grant awards

April 2019: grant agreements executed

* Dates are subject to change based on Board approval

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CalOptima A Public Agency Better. Together.

CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

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

Report Item

17. **Acting as the CalOptima Foundation**, Consider Authorization of Actions Related to the Dissolution of the CalOptima Foundation and Disposition of Remaining CalOptima Foundation Assets

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions

1. Approve Dissolution of the CalOptima Foundation, with the assistance of Legal Counsel, and authorize the Executive Director to complete a Certificate of Election to Wind Up and Dissolve and a Certificate of Dissolution.
2. Authorize the Executive Director, with the assistance of Legal Counsel, to execute any other actions, as necessary to dissolve the CalOptima Foundation.
3. Authorize the Executive Director to return the remaining assets back to CalOptima following completion of dissolution, less necessary costs of wind up and dissolution, if any.

Background

In 2010, the CalOptima Foundation (the Foundation) was incorporated as a 50l(c)(3) nonprofit charitable organization. The specific purpose for which the Foundation was incorporated is "to assist in performing the functions and carrying out the programs of CalOptima." The initial focus of the Foundation was to apply for federal grant funding to operate the CalOptima Regional Extension Center (COREC), which was designed to support implementation of electronic health record systems in provider offices. To date, the Foundation's activities centered around the administration of the approximately $6.7 million federal COREC grant.

Near the Foundation's inception, it entered into an administrative services agreement with CalOptima under which CalOptima would provide certain administrative and technical services in exchange for payment from the Foundation.

Shortly after the Foundation's establishment, the CalOptima Board of Directors undertook a strategic planning process focused on unmet needs in the community impacting the health of CalOptima's members. To address those needs, CalOptima's Board approved the 2013–16 Strategic Plan, aimed in part at providing support for expanding the Foundation.

In March 2014, the CalOptima Board authorized a one-time $3 million transfer to the Foundation from CalOptima's net assets in the Fiscal Year (FY) 2013-14 budget. An expenditure plan was approved a few months later, stating that the intent was to use those transferred dollars for these primary purposes:

- Sustaining and expanding COREC activities ($1.2 million);
- Community health grants to strengthen the safety net, enhance preventative services and support wraparound services for CalOptima members ($1.5 million); and

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- Administrative expenses ($300,000).

The original federal COREC funds were largely exhausted in Fall 2015. As part of the COREC grant, a deliverable included a sustainability plan. CalOptima was interested in pursuing a continuation and extension of COREC services in part because of this sustainability plan requirement. Separate and apart from the Foundation, CalOptima (the public agency) subsequently applied for and was awarded a separate $4.3 million state grant. (The state grant did not require a 501(c)(3) nonprofit charitable organization to apply for the funds.)

CalOptima, the public agency, began directly administering the newly-named electronic health record project, CalOptima Technical Assistance Program (COTAP). With the exhaustion of the original COREC federal grant made to the Foundation, the Foundation is not involved in the COTAP project activities.

At this stage, the majority of $3 million in funds transferred from CalOptima to the Foundation remain unexpended, with a balance of approximately $2.8 million, as of September 2018.

Discussion

Amid the shift from COREC to COTAP and anticipating the need to address the status and future of the Foundation, the CalOptima Board (acting as the Foundation Board) suggested further discussion via the formation of an Ad Hoc committee that met on July 7, 2015, to review the following:

- The purpose for creation of the Foundation;
- Activities of the Foundation;
- Approval of transferring funds from CalOptima (the public agency);
- Impacts and consequences of continuing the Foundation; and
- Comparison with other public health plan Foundation or community benefit programs.

The Ad Hoc committee requested further study in several areas. CalOptima staff researched the topics and provided the following information:

- An organization either is *or* is not qualified under Internal Revenue Code section 501(c)(3) for tax exemption; there is no “inactive” status.
- An organization with 501(c)(3) status may exist indefinitely without conducting any of the activities related to the purpose for which it was created, if administrative duties, such as filing tax returns and other state filings are completed. An exempt organization may be suspended and have its tax exemption revoked for not conducting these administrative functions and filing proper documents.
- The administrative cost to maintain exempt status for the Foundation is nominal. Costs include the filling of the state and federal tax forms annually, the Attorney General’s Registry of Charitable Trust form (RRF-1) annually, and the Secretary of State registration form (SI-100) every two years.
- The transfer of funds between two tax-exempt entities (CalOptima, the public agency, and CalOptima Foundation) does not generate any tax consequences.

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Further discussion and action about the Foundation was postponed and a new CalOptima Board was appointed in July 2016.

At this stage, the COREC initiative has been completed. The Board of Directors requested an update on the status of the Foundation, which was provided at the November 1, 2018, CalOptima Board meeting. At that meeting, the Board directed staff to bring back a recommendation to wind down the Foundation and return any remaining assets after the costs associated with wind down, to CalOptima. Unexpended Foundation assets currently total approximately $2.8 million.

Alternatively, the Foundation Board could, for example, instead direct that the funds allocated to COREC and community health grants be allocated to fund community grants in alignment with the original Foundation expenditure plan to fund a community health grants program. Grants could be made as follows:

Community Grant Requests for Proposal (RFPs):

Grant RFP	Total Grant Award
1. Mental Health Services for Adults: Telehealth Implementation in FQHCs/Community Clinics	$1,500,000
2. Mental Health Socialization Services for Older Adults	$400,000
3. Mental Health/Developmental Services for Children	$400,000
4. Medi-Cal Benefits Education and Outreach	$400,000
Total Grant Funding:	$2,700,000

After grant funds are distributed, any remaining assets would be set aside to cover necessary costs of dissolution and associated activities, if any.

With almost no remaining assets, the Foundation staff may then begin a dissolution process, including compliance with the requirements of the California Secretary of State and Attorney General, and the additional steps as noted below, provided that there are no remaining tasks or reports that need to be completed under the original COREC grant.

The process of dissolving the Foundation may be initiated by a resolution of the Foundation Board. Some additional steps will be required, including, but not limited to:

- Filing a certificate of election to dissolve with the California Attorney General;
- Reviewing and retiring Foundation activities and policies, and distributing any other remaining assets;
- Filing a certificate of dissolution with Secretary of State;
- Filing a final dissolution packet with California Attorney General; and
- Filing final tax returns.

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Fiscal Impact

The recommendations to authorize actions to dissolve the CalOptima Foundation has no material fiscal impact on CalOptima. The cost to wind up and dissolve the CalOptima Foundation are anticipated to be nominal (e.g., filing fees) and would be paid prior to the return of the remaining assets to CalOptima. Remaining assets from the CalOptima Foundation after costs of wind up and dissolution will be returned back to CalOptima.

Rationale for Recommendation

The CalOptima Foundation has had no significant activity conducted since 2015. Additional research demonstrated that most Medi-Cal health plans conduct community health benefit activities, such as grant making, directly from the plan, and do not have a separate foundation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: CalOptima Foundation: Recommendation
2. CalOptima Board Action dated March 6, 2014, Approve Proposed Work Plan for CalOptima Foundation and Approve Transfer of Fiscal Year 2013-14 Budget Allocation to CalOptima Foundation
3. CalOptima Foundation Board Action dated September 4, 2014, Authorize the Fiscal Year (FY) 2014-15 CalOptima Foundation Expenditure Plan

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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CalOptima Foundation:

Recommendations

CalOptima Board of Directors

December 6, 2018

Cheryl Meronk

Director, Strategic Development

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Agenda

1. CalOptima Foundation Creation
2. Foundation Activities (COREC)
3. Ad Hoc Committee Key Questions and Answers
4. Foundation Current Status
5. Recommendations

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CalOptima Foundation Creation

- CalOptima Foundation is a 501(c)(3) nonprofit corporation formed in 2010

- Foundation was created to apply for a one-time federal grant of $6.7 million to operate the CalOptima Regional Extension Center (COREC)
  - At the time, CalOptima (the public agency) was not eligible to receive the grant
  - Only 501(c)(3) corporations were eligible to apply for funding

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Foundation Activities

- Since the Foundation's formation, activities have focused only on operation of COREC
- COREC assisted more than 1,200 Orange County primary care physicians with implementing electronic health record (EHR) systems
- Federal COREC funds were exhausted in Fall 2015

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Foundation Activities, cont.

- September 2014: $3 million one-time transfer from CalOptima to the Foundation, for the following purposes:
  - $1.2 million for COREC expansion
    - Extended the program to include specialists
  - $1.8 million for community health grants
    - Strengthen the Safety Net
    - Enhance Preventative Services
    - Support for wrap-around services for CalOptima members
    - Support for administrative expenses
- June 2015: DHCS technical assistant grant made to CalOptima (not the Foundation)
  - $4.3 million awarded by the state for expansion of program related to electronic health records

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Ad Hoc Committee – Background

- May 2015 - the CalOptima Board of Directors suggested further discussion as to the future and role of the CalOptima Foundation
  - Ad Hoc Committee was formed

- July 2015 - Ad Hoc committee members met and asked staff to conduct further research on questions relating to the Foundation

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Ad Hoc Committee – Key Questions

1. What are the different categories/levels of 501(c)(3)? (e.g., can Foundations exist in inactive or active status)?

2. What are some of the estimated administrative costs to keep the 501(c)(3) non-profit charitable organizations in an inactive status (if applicable)?

3. If the Foundation is in an in-active status, how long (potentially) before the state could recommend closing down the non-profit organization?

4. Will there be any tax or legal ramifications to CalOptima or the Foundation to transfer the $3M back to CalOptima?

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Responses to Key Questions

1. An organization either is or is not qualified under 501 (c)(3) for a tax exemption; there is no “inactive” status

2. An organization with 501 (c)(3) status can exist indefinitely without conducting any of the purpose for which it was created

3. The administrative cost to maintain exempt status for the CalOptima Foundation is nominal. An organization can exist indefinitely as long as administrative duties, such as filing tax returns and other State filings are completed

4. The transfer of funds between two tax exempt entities (CalOptima the public agency and the CalOptima Foundation) does not generate any tax consequences

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Foundation Status

- Currently an existing 501(c)(3), non-profit, charitable organization
- Approximately $2.8 million in Foundation balance
  - Majority of funds are unallocated
- Ongoing administrative costs to maintain 501(c)(3) status
  - Conduct annual financial audits
  - File for state and federal tax-exempt status (e.g., Form 990)
  - Submission of forms RRF-1 and SI-100
  - Use of staff time
- No activities/grant awards conducted

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Recommendation

- Return unexpended funds, approximately $2.8 million to CalOptima (the public agency)
- Take steps to begin the process to dissolve the Foundation as noted, which include:
  - Filing a certificate of election to dissolve with the California Attorney General
  - Reviewing and retiring Foundation activities and policies, and distributing any other remaining assets
  - Filing a certificate of dissolution with Secretary of State
  - Filing a final dissolution packet with California Attorney General
  - Filing final tax returns

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Alternative Recommendation

- Consider the use of Foundation funds allocated for COREC and community health grants to be used for community grants
  - CalOptima's Member Health Needs Assessment and Request for Information (RFI) responses have identified categories for community grants

- Any remaining assets after grant distribution would cover any cost of dissolving the Foundation and associated activities

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Four Proposed Grant RFPs

RFP #	RFP Description	Funding Amount
1	Mental Health Services for Adults (Telehealth at FQHCs/Community Clinics)	$1.5 million
2	Mental Health and Socialization Services for Older Adults (65+ years)	$400,000
3	Mental Health/Developmental Services for Children 0–5	$400,000
4	Medi-Cal Benefits Education and Outreach	$400,000
	Total	**$2.7 million**

* Multiple awardees may be selected per RFP

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RFP 1

Expand Access to Adult Mental Health Services Through Telehealth: FQHCs/Community Clinics

- **Funding Amount:** $1.5 million
- **Description:**
  - Provide mental health care services to adults ages 19–64 in a FQHC/community clinic setting via telehealth methods
  - Offer services including but not limited to:
    - Access to specialty mental health services such as psychiatry etc.
    - Multiple modes of telehealth, such as live video conferencing, telephone, etc.
    - Evaluation/assessments and treatment/counseling at more accessible days and times
    - Timely medication(s) prescribing
    - Appropriate training so qualified clinical/administrative staff can provide services

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RFP 2

Expand Access to Older Adult Mental Health and Socialization Services

- **Funding Amount:** $400,000
- **Description:**
  - Provide community-based socialization services, focusing on Farsi- and Korean-speaking older adults, along with adults speaking other threshold languages
  - Offer resource referral, linkage and follow-up to ensure activities/services are successful, such as:
    - Educational and social activities (e.g., language classes)
    - Peer mentoring services (e.g., computer/technology classes)

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RFP 3

Expand Access to Children's Mental Health/Developmental Services

- **Funding Amount:** $400,000
- **Description:**
  - Provide mental health services to children, ages 0–5, through partnership with mental health care professionals and early education staff
    - Increase access to early developmental and intervention screenings through trainings that enable additional qualified individuals to conduct screenings
    - Refer and/or provide direct access to therapies and/or interventions for children, families and other caregivers
    - Use a community-based health system navigator model to connect members to services

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RFP 4

Medi-Cal Benefits Education and Outreach

- **Funding Amount:** $400,000
- **Description:**
  - Provide information about Medi-Cal benefits and coverage as well as information and assistance with annual renewal
  - Deliver services in a one-on-one and/or group setting
  - Use a health navigator model to assist members to access and connect to Medi-Cal services and other resources
  - Provide services in high-need and hard-to-reach ethnic communities speaking CalOptima threshold languages
  - Ensure health care navigators are easily accessible in the community

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March ~~7~~ 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. E. Approve Proposed Work Plan for CalOptima Foundation and Approve Transfer of Fiscal Year 2013-14 Budget Allocation to CalOptima Foundation

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve proposed work plan for CalOptima Foundation; and
2. Approve transfer of a $3 million Fiscal Year 2013-14 budget allocation to the CalOptima Foundation.

Background

The CalOptima Foundation obtained 501(c)(3) designation in 2010 as part of a successful effort to seek Federal funding to operate the CalOptima Regional Extension Center (COREC). It is governed by the CalOptima Board, acting in its capacity as the Foundation Board an average of two to four times per year to conduct business relating to COREC and required annual functions (e.g., budget, audit). Currently, the Foundation's activities include the administration of the COREC grant which was awarded to CalOptima by the U.S. Department of Health and Human Services' Office of the National Coordinator to assist primary care physicians implement electronic medical record systems.

In conjunction with CalOptima's Board-approved 2013-16 Strategic Plan, expanding the function of the Foundation to complement the work of the health plan in better serving members is a strategic objective under the Financial Stability priority. The Fiscal Year 2013-14 budget includes a $3 Million set-aside for the Foundation.

Discussion

Current and planned Foundation activities include:

- Sustaining and expanding COREC services to increase meaningful use of electronic health records by primary and specialty care physicians serving Medi-Cal members;
- Transitioning current development and community-centered activities to the Foundation for greater plan efficiency, including:
    - Increasing provider capacity and incubating emerging programs or models that address unmet community needs;
    - Supporting community programs, such as community health promotion and Medi-Cal outreach and enrollment events;
- Pursuing federal and foundation grants and partnering with community groups on solutions to healthcare gaps.

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A high-level work plan for Foundation expansion planning is included in the attached presentation. Staff recommends proceeding with implementation of the proposed work plan during the current fiscal year, with funding commitments consistent with the Foundation's filing status and available funding taking place in FY 2014-15.

Fiscal Impact
The recommended action would result in an estimated expenditure of $3 million for CalOptima Foundation which would be funded from CalOptima reserves as established in June 2013.

Rationale for Recommendation
Continuation and expansion of the CalOptima Foundation's functions to support activities that address service gaps experienced by CalOptima members and the community is consistent with the Board-approved 2013-16 Strategic Plan. These activities also complement current efforts to implement health information technology to improve delivery and coordination of care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *2/28/2014*
Authorized Signature — **Date**

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CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2014
Meeting of the CalOptima Foundation Board of Directors

Report Item
VII. E. Authorize the Fiscal Year (FY) 2014-15 CalOptima Foundation Expenditure Plan

Contact
Michael Ruane, Executive Director, (714) 246-8400

Recommended Action
Authorize the FY 2014-15 CalOptima Foundation Expenditure Plan.

Background and Discussion

Foundation History and Role
The CalOptima Foundation (Foundation) obtained 501(c)(3) designation in 2010 as part of a successful effort to seek federal funding to operate the CalOptima Regional Extension Center (COREC). It is governed by the CalOptima Board, acting in its capacity as the Foundation Board an average of 2 to 4 times per year to conduct business and required annual functions (e.g., budget, audit). Currently, the Foundation's activities center on the administration of the COREC grant.

Foundation Expansion Planning
In conjunction with CalOptima's Board-approved 2013-16 Strategic Plan, expanding the function of the Foundation to complement the work of CalOptima the health plan in better serving members is a strategic objective under the Financial Stability priority. The Board-approved Fiscal Year 2014-15 CalOptima budget includes a $3 million set-aside for the Foundation.

In March 2014, CalOptima's Board approved a high-level work plan for Foundation expansion with funds allocated to two main categories: (1) the expansion of COREC services and (2) implementation of a Community Health Grant Program.

Extension of COREC Services – Approved Amount: $1.2 Million

The COREC grant was awarded to the CalOptima Foundation by the U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, to assist Orange County healthcare providers with implementation of electronic health record (EHR) systems and attainment of meaningful use certification. Meaningful use refers to providers' ability to use EHR technology to improve quality, safety and efficiency.

Federal guidelines define three tiers of progressively more sophisticated meaningful use criteria, described generally as follows:

- Stage 1: Capture data and share internally
- Stage 2: Share information with multiple providers, including specialists and hospitals
- Stage 3: Show documented improvement in patient outcomes.

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Consistent with these requirements, the COREC has worked with approximately 1,000 Orange County Primary Care Providers (PCPs) to achieve Stage 1 meaningful use and is assisting these providers with meeting Stage 2 criteria, which became more stringent in 2014. Many of these providers are requiring additional resources and technical assistance to meet the January 1, 2015 deadline for Stage 2 criteria and avoid a 1 percent cut to their Medicare reimbursement; this support is being funded through IGT funds.

With the approved Foundation funding, COREC will extend its services as follows:

- Provide meaningful use supports for 114 PCPs and 430 specialists (program is currently limited to PCPs);
- Improve health care access and delivery, for example through enhanced clinical data analytics and assisting providers in adopting telemedicine delivery models.

It is anticipated that the full $1.2 million allocation will be applied toward costs associated with assisting provider practices to select and implement an EHR system and achieve federal meaningful use criteria of the new technology. COREC staffing costs are excluded from the Foundation budget since they were previously included as part of the approved CalOptima Medi-Cal FY 2014-15 Operating Budget.

Community Health Grant Program – Approved Amount: $1.8 Million

At its March 2014 meeting, CalOptima's Board designated funding to invest in promising practices and approaches to address community needs and gaps. Some options to explore include:

- Strengthening the safety net, for example by enhancing community clinic capacity;
- Expanding access to and use of preventive services, such as developmental, vision and dental screening;
- Providing wraparound services and promoting integration of services for vulnerable populations, such as homeless members and foster children.

To provide further guidance, staff has convened a MAC/PAC ad hoc subcommittee to review available data and provide recommendations for grant-making priorities. The group is scheduled to complete its work in the September - October timeframe. CalOptima subject matter experts will then review the group's input and propose a final set of funding recommendations (with corresponding budget amounts) to the Board for consideration.

Proposed Budget

The proposed CalOptima Foundation FY 2014-15 Expenditure Plan is presented in the table below. This budget includes a line item for general and administrative expenses related to administration of Foundation business, which was not specifically carved out in the preliminary budget presented to the Board in March 2014. Staff recommends that $300,000 be moved from the Community Health Program allocation for this purpose.

In accordance with accepted practices in nonprofit management, the Foundation's administrative costs will not exceed 10% of the total operating budget, or $300,000, for FY 2014-15. Salaries and benefits for 2.0 FTEs are the main expenditure. During the start-up period these expenditures may be utilized to reimburse current staffing costs, supports and Foundation activities. The scope of work for the

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proposed positions includes administering competitive grant processes for each of several funding priorities; developing agreements with grantees; monitoring grant performance; providing technical assistance to grantees; and reporting on grant outcomes.

Recommended FY 2014-15 CalOptima Foundation Expenditure Plan

	FY 2014-15 Budget
COREC:	
Professional fees for contracted service partners for technical assistance to PCPs and specialists	$1,200,000
Community Health Grant Program:	
Grants for select funding priorities	$1,500,000
Administrative Expenses:	
Salaries, Wages & Benefits	$210,000
Professional Fees	$50,000
Printing & Postage	$10,000
Other Operating Expenses	$30,000
Subtotal	$300,000
Total	$3,000,000

Fiscal Impact
The recommended action provides additional details on expenditures of the FY 2013-14 budget allocation of $3 million for the CalOptima Foundation, approved at the March 6, 2014 CalOptima Board meeting.

Rationale for Recommendation
Continuation and expansion of the CalOptima Foundation's functions to support activities that address service gaps experienced by CalOptima members and the community is consistent with the Board-approved 2013-16 Strategic Plan. These activities also complement current efforts to implement health information technology to improve delivery and coordination of care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

8/29/2014 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

18. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

Contact

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

Recommended Actions

1. Authorize expenditure for CalOptima's participation in the following community events:
    a. Up to $10,000 and staff participation at the Vietnamese Community of Southern California (VNCSC) 2019 Year of the Pig Tet Festival in Fountain Valley on February 8-10, 2019;
    b. Up to $10,000 and staff participation at the Union of Vietnamese Student Associations Southern California (UVSA) 38th Annual Tet Festival Year of the Pig in Costa Mesa on February 8-10, 2019; and
    c. Up to $2,500 for CalOptima's participation in the Family Voices of California (FVCA) 2019 17th Annual Health Summit and Legislative Day on March 10-12, 2019 in Sacramento.
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

Staff recommends the authorization of expenditures for participation in the two Lunar New Year Tet Festivals scheduled in Orange County (Fountain Valley and Costa Mesa). The events will provide CalOptima opportunities to interact with our Vietnamese members and other festival attendees about our programs and services. Vietnamese members comprise approximately twelve percent of

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CalOptima's total membership. Staff also recommends the authorization of expenditures for participation in the FVCA 2019 Annual Health Summit and Legislative Day (Summit) in Sacramento. Staff believes that participation will strengthen CalOptima's partnership with FVCA and ensure that Orange County California Children Services (CCS) families are engaged with the changes to the program.

The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

a. A $10,000 financial commitment for VNCSC's Tet Festival 2019 Year of the Pig in Fountain Valley includes Gold Sponsorship plus additional banner displays. Overall, sponsorship benefits at this level will consist of one (1) 20x20 exhibitor booth in a prime location, two (2) 4' x 10' banner displays on stage, three (3) 3' x 8' banner displays, twenty (20) mentions on stage, twenty-five (25) radio impressions, and full ad on ten thousand (10,000) fliers distributed throughout the OC and LA prior to the event. Employee time will be used to participate in this event. Employees[TN1] will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. The Fountain Valley festival will take place locally near the largest Vietnamese community in Orange County as well as draw from communities throughout the county. Last year's event drew in over 20,000 attendees. The VNCSC organizer represented that the 2019 event is anticipated to attract up to 80,000 attendees.

b. A $10,000 financial commitment for UVSA's 38th Annual Tet Festival Year of the Pig in Costa Mesa includes includes Silver Sponsorship plus additional sponsor options. Overall, sponsorship benefits will include: two (2) 10'x20' exhibitor booths in prime location, booth listing in event program book, two (2) CalOptima banners at the gate and food court, three (3) graphic impressions on the main stage, booth listing in festival program booklet, CalOptima's logo on promotional posters and fliers, CalOptima's logo on UVSA's Tet Festival website for one (1) year, CalOptima's logo on 500 volunteer t-shirts, social media impression on Facebook event page, full page color add, three (3) graphic impressions on main stage, forty (40) admission tickets, four (4) VIP admission badges, and four (4) VIP parking permits . Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. The Costa Mesa festival attracts over 60,000 attendees from local communities within and outside the county.

c. A $2,500 financial commitment for FVCA's 2019 Health Summit and Legislative Day includes: Sponsorship for one (1) Orange County family representative to attend the Summit, CalOptima's logo on all marketing materials for the Summit and verbal recognition at the event.

   FVCA is a statewide collaborative of parent advocates focused on improving policies that ensure quality health care for children with special needs. FVCA also operates seven parent-run centers, providing information and support so families can make informed decisions about their children's health care. FVCA has been an influential advocacy

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organization working closely with DHCS and the Legislature on redesigning the CCS program. Specifically, FVCA has reached out to Medi-Cal managed care plans, including CalOptima, to begin working together to ensure the CCS transition from fee for service to managed care is done in a responsible manner. FVCA representatives currently hold two seats on the DHCS CCS Advisory Group, which has been the primary vehicle for health plans, providers and children's advocates to discuss the CCS transition.

The Summit will bring together families, advocates, state agency representatives, Medi-Cal managed care plans, health policy advocates, legislative representatives and CCS providers to address issues that affect this vulnerable population. Last year, the Summit drew 185 participants, including 98 family members throughout California. Orange County families with children enrolled in the CCS program have expressed interest in attending the event.

CalOptima staff has reviewed the request and it meets the consideration for participation as required in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability;
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations department. The Community Relations department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $22,500 to participate in the Lunar New Year Festivals and allow for one (1) Orange County family to participate in the FVCA 2019 Annual Health Summit and Legislative Day is included as part of the Community Events budget under the CalOptima Fiscal Year 2018-19 Operating Budget approved by the CalOptima Board of Directors on June 7, 2018.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness, and/or develop and strengthen partnerships in support of CalOptima's programs and services.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
Event Information Packages

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

11/28/2018 — **Date**

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VIETNAMESE COMMUNITY OF SOUTHERN CALIFORNIA
CỘNG ĐỒNG VIỆT NAM NAM CALIFORNIA
Domestic Non-Profit Corporation No. C1479500 • Founded 1990
P.O. Box 457 • Garden Grove, CA 92842-2316
Email: contact@vncsc.org • Website: www.vncsc.org
Tel. (714) 248-6191 • Fax: (877) 648-3383

November 26th 2018

Dear CalOptima,

We are writing you concerning a sponsorship opportunity to celebrate the upcoming Lunar New Year 2019, the Year of the Pig.

The Vietnamese Community of Southern California (VNCSC) has the honor of being selected to work with County of Orange and OC Parks to organize the 2019 OC Tet Festival at Mile Square Regional Park in Fountain Valley, from February 8th to February 10th 2019. This 3-day special event is free and open to the public.

For more than 25 years, the VNCSC has been a strong and influential voice for Orange County Little Saigon, the largest and most established Vietnamese-American Community in the U.S. With the collaboration of other non-profit organizations, we have provided resources to help our many members of the community at large.

As a sponsor of the 2019 OC Tet Festival, you will enjoy extensive media and community exposure prior to and during the 3-day event. As in past years, we expect to have many tens of thousands visitors from all over Orange County as well as throughout Southern California and the United States, to ring in the Lunar New Year.

This festival will be shown live and rebroadcast on television and social media. The media exposure for CalOptima would be far reaching. We cordially invite you to join our festivities and become a prestigious sponsor for this event.

Your sponsorship of $10,000 will be a significant contribution to this wonderful annual tradition. If you need any further information, please feel free to contact us at:

Vietnamese Community of Southern California (VNCSC)
14190 Beach Blvd., Westminster, CA 92683
Office hours: Monday – Friday from 1:00 PM – 5:00 PM
Phone number: (714) 248-6191, Email address: info@vncsc.org,

Sincerely,

Vietnamese Community of Southern California.

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2019 OC TET FESTIVAL SPONSOR PACKAGE

BRONZE SPONSOR $2,000
> 10′ x 10′ booth in prime location at the Tết Festival Mile Square Park
> One (1) 3′ x 8′ banner display
> Five (5) mentions on stage

SILVER SPONSOR $5,000
> 20′ x 10′ booth in prime location at the Tết Festival Mile Square Park
>Two (2) 3′ x 8′ banner displays
>Ten (10) mentions on stage
> Fifteen (15) radio impressions
> Full ad size 5.5 x 8.5 inches (the other side will be Tết Festival Mile Square Park announcement) on five thousand (5,000) flyers distributed throughout OC & LA prior to the event

GOLD SPONSOR $8,000
> 20′ x 20′ booth in prime location at the Tết Festival Mile Square Park
> Three (3) 3′ x 8′ banner displays
> Twenty (20) mentions on stage
> Twenty-five (25) radio impressions
> Full ad size 5.5 x 8.5 inches (the other side will be Tết Festival Mile Square Park announcement) on ten thousand (10,000) flyers distributed throughout OC & LA prior to the event

DIAMOND SPONSOR $15,000
> 30′ x 20′ booth in prime location at the Tết Festival Mile Square Park
> Five (5) 3′ x 8′ banner displays
> Thirty (30) mentions on stage
> Forty (40) radio impressions
> Full ad size 5.5 x 8.5 inches (the other side will be Tết Festival Mile Square Park announcement) on twenty thousand (20,000) flyers distributed throughout OC & LA prior to the event

OPTIONAL:

- 3′ x 8′ banner printing & display at Tết Festival Mile Square Park $350
- 4′ x 10′ vertical banner printing & display front left & right of Tết Festival Mile Square Park Stage $1,000 per piece (only 2 pieces available)
- 8′ x 8′ backdrop on Tết Festival Mile Square Park Stage $1,500 per piece (only 2 pieces available)
- Full ad size 5.5 x 8.5 inches (the other side will be Tết Festival Mile Square Park announcement) on five thousand (5,000) flyers distributed throughout OC & LA $400 (only 8 cents/impression) prior to the event

(*) Sponsorship packages subject to modifications without notice

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TẾT

FESTIVAL
SPONSORSHIP PROPOSAL

FEBRUARY 8-10, 2019
OC FAIR & EVENT CENTER

Celebrating the Year of the Pig

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DEAR PROSPECTIVE SPONSOR,

The Union of Vietnamese Student Associations Southern California (UVSA) is proud to submit this proposal for your review. We wish to provide your organization with unique and advantageous marketing opportunities to promote your brand and business to the Vietnamese community.

The 38th Annual UVSA Tết Festival will take place between February 8 and February 10, 2019 at OC Fair & Event Center — adjacent to Costa Mesa, Newport Beach, Santa Ana, and Irvine. The event attracts over 60,000 attendees, encompassing a multi-ethnic populace with strong Asian American presence.

The event is recognized as the most distinguished Vietnamese Lunar New Year celebration in the nation for many reasons:

- We coordinate the largest Tết Festival in the nation with 37 years of success
- UVSA is one of the four pillars upholding the Vietnamese community in cooperation with the Vietnamese American Federation of Southern California, the Coalition of Vietnamese Armed Forces, and the Association of Vietnamese Language & Culture Schools of Southern California
- We are the strongest Vietnamese youth organization in the country and we represent students and young leaders in the Santa Barbara, Los Angeles, Riverside, San Bernardino, and San Diego counties
- Our involvement in the Vietnamese community is built upon cultural awareness, education, and social and civic engagement
- We provide leadership opportunities to over 300 volunteers
- UVSA is a 501(c)3 grant-giving organization and has awarded over $1,500,000 in festival proceeds to deserving non-profit organizations across Southern California

We cordially invite your team to join us this year in making UVSA Tết Festival the most spectacular yet! We look forward to building a partnership with you as we welcome the Year of the Pig, with prosperity and success for all. Thank you for your consideration.

Sincerely,

Julie T. Nguyen
Sponsorship Director
tet.sponsorship@uvsa.org

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FESTIVAL SUMMARY

EVENT

38th Annual UVSA Tết Festival

DESCRIPTION

Tết is a celebration of the Lunar New Year, the most observed holiday for Vietnamese people

OBJECTIVES

1. To celebrate the new lunar year
2. To preserve and promote Vietnamese culture
3. To share Vietnamese tradition with surrounding communities
4. To provide opportunities for organizations to promote their products and services to the Vietnamese American market
5. To raise funds to support educational and cultural programs in the community
6. To bring Vietnamese youths together and provide them with opportunities for leadership development and community service

DATES

Friday, February 8, 2019; 4PM - 10PM
Saturday, February 9, 2019; 11AM - 10PM
Sunday, February 10, 2019; 11AM - 9PM

LOCATION

OC Fair & Event Center
88 Fair Dr., Costa Mesa, CA 92626

ATTENDANCE

60,000+ patrons
300+ vendors and sponsors

Lion dancers performing at the Saturday Opening Ceremony

ACTIVITIES

Lion Dancing	Prize Booths	Grand Concert
Firecrackers	Miss Vietnam Pageant	Talent Show
Carnival Games	Traditional Dances	Youth Night
Children's Pageant	Martial Arts	Pho Eating Contest
Cultural Ceremony	Carnival Rides	Community Exhibitions
Cultural Village	Cultural Foods	Special Guests

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HOSTING ORGANIZATION

ABOUT The Union of Vietnamese Student Associations of Southern California (UVSA) is a 501(c)3 non-profit, non-partisan, community-based organization founded in 1982 consisting of students, alumni, young professionals, and community leaders. Our mission is to bring together Vietnamese American students and young professionals across Southern California to build unity, to serve the community, and to advocate for social justice issues that affect our community domestically and in Vietnam.

GRANTS Each year, half of net profits from the event are allocated towards the Tết Community Assistance Fund. Over the past 15 years, UVSA has awarded over $1.5 million to help Southern California non-profit organizations initiate community enrichment programs.

MEMBERS UVSA was founded on volunteerism and continues to be a 100% volunteer-based organization. With over 50 year-round staff, 300 project staff, and 500 day-of volunteers, UVSA strives to equip each volunteer with skillsets that will help them excel in their professional careers. Additionally, UVSA partners with local, self-governing Vietnamese student associations from the following universities:

Chapman	CSU Long Beach	UC Riverside
Cal Poly Pomona	CSU Northridge	UC Santa Barbara
CSU Fullerton	San Diego State	UC San Diego
CSU Los Angeles	UC Irvine	University of Southern California

DEMOGRAPHICS & STATISTICS

According to the 2018 U.S. Census, 1,548,449 people identify as Vietnamese, ranking them fourth among the Asian American groups; 447,032 (40%) of them live in California. The largest Vietnamese population outside of Vietnam is found in Southern California—totaling over 300,000 members from Los Angeles, Orange, and San Diego counties. Vietnamese American businesses continue to grow in areas such as Garden Grove and Westminster while rapidly extending lucrative development to surrounding cities.

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KEY BENEFITS

The success of this event depends on the generosity of sponsors. In return, UVSA aims to provide sponsor with the following benefits:

- Brand awareness and brand loyalty from current and prospective buyers
- High-level media exposure from local television stations, radio stations, magazines, newspapers, and advertisements
- Large-scale onsite product promotion and face-to-face customer interaction
- Positive public outreach and market response
- Recognition as an industry leader above competitors
- Tax-deductible gift receipt for contributions involving no exchange of goods or services

Toyota showcases their latest vehicles in a custom 30' x 40' booth

The Miss Vietnam of Southern California Royal Court pose for Lexor's custom 20' x 10' booth

The Miss Vietnam of Southern California Royal Court pose for Sunpower's 20' x 20' booth

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SPONSOR PACKAGES

Your company's sponsorship directly impacts the success of the UVSA Tết Festival. We offer the following packages, which include standard benefits or the option to tailor your participation to meet company goals. We hope that you take this opportunity to sponsor the event as a means to promote brand loyalty from a very accomplished community. All monetary contributions in which there is no exchange of goods or services are tax-deductible. Please contact our Sponsorship Director for more information.

	SPONSOR BENEFITS	MEDIA OR IN-KIND TRADE (varies with value)	BRONZE $3,500	SILVER $6,000	GOLD $12,000	DIAMOND $23,000	TITLE $40,000
PRE-FESTIVAL	Logo on all promotional posters	✓	✓	✓	✓	✓	✓
	Logo and link on event website for 1 year	✓	✓	✓	✓	✓	✓
	Logo on event ad in Vietnamese newspapers impressions (up to 500k)				✓	✓	✓
	Vietnamese radio impressions (up to 100k)				✓	✓	✓
	Vietnamese television impressions (up to 60k)				✓	✓	✓
	Social media post (up to 6,000 people reached)					1	2
ON-SITE	Booth in prime location	10' x 10'	10' x 10'	10' x 20'	20' x 20'	20' x 30'	20' x 40'
	Booth listing in event program book	✓	✓	✓	✓	✓	✓
	Admission tickets	30	30	40	60	100	150
	VIP 3-day admission badges	2	2	4	6	8	12
	VIP 3-day parking hang tags	2	2	4	6	8	12
	Banner display near main entrance	1	1	1	1	1	1
	Graphic ad impressions on main stage			3	3	6	12
	Banner display near main stage				1	2	4
	Banner display near exit gate				1	1	1
	Mentions on main stage				5	10	15
	Color ad on in event program book				1/2 page	full page	back cover
	Recognition during Opening Ceremony				✓	✓	✓
	Logo display on event ticket booth window					2	3
	Logo on back of 500 volunteer t-shirts					✓	✓
	30-second video ad on Main Stage					3 runs	6 runs
	Color ad in pageant program book					1/2 page	full page editorial
	Logo on event directory					✓	✓
	Banner display on event ticket booth						3
	Banner ad with link on event website						✓
	Logo on event billboard in Little Saigon						✓
	Logo on online admission tickets						✓
	Logo on the back of printed admission tickets						✓
	Speech at opening ceremony on main stage						5 minutes
	Present scholarship check to pageant winner						✓
	Speech at pageant closing on main stage						5 minutes
	Sponsor mentions on PA system looped inside event entrance area						✓

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PLEDGE FORM

COMPANY NAME: _____

CONTACT NAME: _____ TITLE: _____

PHONE: ( ) _____ EMAIL: _____

SPONSORSHIP PACKAGE

- ☐ BRONZE
- ☐ SILVER
- ☐ GOLD
- ☐ DIAMOND
- ☐ TITLE
- ☐ MEDIA TRADE
- ☐ IN-KIND TRADE
- ☐ CUSTOM OR A LA CARTE
- ☐ DONATION ONLY

PLEASE TELL US ABOUT YOUR COMPANY: _____

_____

_____

_____

_____

A LA CARTE SPONSOR OPTIONS

Banner display near main entrance — $500
Logo link on event website for 1 year — $500
Banner ad link on event website for 1 year — $750
Logo on back of 500 volunteer t-shirts — $500
Social media impression on Facebook event page — $500
Social Media promo video post — $1,000 (1 min)
Additional 1'0 x 10' booth in prime location — $3,000
Prize Donations — VARIES

Main Stage Ad impression:
- Graphic — $500 (3x)
- 30-second video — $750 (3x)
- Prime Time video — $1,000 (3x)

Program Book Ad (60,000)
- Quarter-page color — $1,000
- Half-page color — $2,000
- Full page color — $3,000

Presenting Sponsor (please ask for list of benefits):
- Pho Eating Contest — $1,500
- Children's Pageant — $3,000
- Talent Show — $3,000
- Youth Night — $3,000
- Grand Concert — $5,000

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UNION OF VIETNAMESE STUDENT ASSOCIATIONS OF SOUTHERN CALIFORNIA

"DEVELOPING THE NEXT GENERATION OF LEADERS"

JULIE T. NGUYEN

Sponsorship Director

Tel: (714) 388-6711

Email: tet.sponsorship@uvsa.org

MAIL

PO BOX 2069

WESTMINSTER, CA 92684

WEBSITE

WWW.UVSA.ORG | WWW.TETFESTIVAL.ORG

THANK YOU TO OUR 2018 FESTIVAL SUPPORTERS

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FAMILY VOICES of California

The voice of families
The vision of quality health care
The future for children and youth with special health care
d

Alpha Resource Center of Santa Barbara
4501 Cathedral Oaks Road
Santa Barbara, CA 93110
(805) 683-2145
info@alphasb.org

Eastern Los Angeles Family Resource Center
1000 South Fremont Avenue
Suite 6050, Unit 35
Alhambra, CA 91803
(626) 300-9171
info@elafrc.org

Family Resource Navigators
291 Estudillo Avenue
San Leandro, CA 94577
(510) 547-7322
eileenc@frnoakland.org

Support for Families of Children with Disabilities
1663 Mission Street, Suite 700
San Francisco, CA 94103
(415) 282-7494
info@supportforfamilies.org

FAMILY VOICES OF CALIFORNIA
1663 Mission Street,
Suite 700
San Francisco, CA 94103
(415) 282-7494

info@familyvoicesofca.org
www.familyvoicesofca.org

October 25, 2018

Tiffany Kaaiakamanu
Manager, Community Relations
CalOptima

Re: Sponsorship Request for Family Voices of CA 2019 Health Summit

Dear Tiffany:

Family Voices of California (FVCA) provides families of children and youth with special health care needs (CYSHCN) with information, tools, and support to advocate for better access to high quality care. We build partnerships, inform stakeholders, and foster parent engagement to give families a voice in healthcare policy making.

We would like to request sponsorship for our 2019 Annual Health Summit and Legislative Day, which will be held on March 10-12, 2019, in Sacramento so that we may continue to advance these efforts.

Advocates, health care providers and professionals, government representatives, and legislators and staff will join parents and caregivers for updates on health policy issues facing CYSHCN. Speakers will provide policy and program updates, and families will share perspectives on the impact of policies on their lives. The Summit will be followed by legislative meetings at the State Capitol, where families will educate lawmakers about the issues they face and put a personal face on the impact of legislation and budget decisions.

With your sponsorship we can make our 2019 Summit a great success by:

- Educating and informing parents and decision makers about critical issues facing CYSHCN.
- Building collaboration among families, legislators, regulators, providers, and community based organizations to increase parent involvement at all levels of community and government health policy making.
- Engaging parents in policymaking through legislative meetings.

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Nearly 100% of those attending our 2018 Summit agreed that the support, information, and resources they received helped them feel more confident about getting their child the health care and services they need; and as a result they took action during Legislative Day and beyond. With your support FVCA can continue our work to advance public policies and system improvements that will help families of CYSHCN access the care they need.

Please see the attached menu of sponsorship activities, and don't hesitate to contact me for more information at pipmarks@familyvoicesofca.org or 415-282-7494 ext. 123.

Thank you for your consideration of this request!

Sincerely,

Pip Marks
Project Director

FAMILY VOICES of California

2019 Health Summit Sponsorship Commitment

March 10-12, 2019
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please return your completed form to Pip Marks at pipmarks@familyvoicesofca.org or 1663 Mission Street, Suite 700, San Francisco, CA 94103

☐ **Leadership – $10,000**

A speaking role at the Summit
Verbal recognition at the Summit
Prominently placed logo on Summit materials
Inclusion of 1 item in attendee packets
Inclusion in social media marketing
Summit attendance for 3 representatives

☐ **Spirit – $5,000**

Verbal recognition at the Summit
Logo on Summit materials
Inclusion in social media marketing
Inclusion of 1 item in attendee packets
Summit attendance for 2 representatives

☐ **Partner – $2,500**

Verbal recognition at the Summit
Logo on Summit materials
Summit attendance for 1 representative

☐ **Collaboration – $1,500**

Verbal recognition at the Summit
Listing in Summit materials
Summit attendance for 1 representative

☐ **Hope – $800 x _____ = $ _____** **(**Sponsor a family to attend the Summit)

Listing in Summit materials

Sponsor a family of a child with special health care needs to attend the Summit. Each family sponsorship provides travel, lodging, and childcare for 1 family.

☐ **Other – Donation**

Amount:

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FAMILY VOICES of California

2019 Health Summit Sponsorship Commitment

March 10-12, 2019
Holiday Inn Sacramento – Capitol Plaza
300 J Street, Sacramento, CA 95814

Please make checks payable to:
Support for Families of Children with Disabilities
and reference/memo Family Voices of California

Please return your completed form and send to:

Pip Marks at pipmarks@familyvoicesofca.org
or
1663 Mission Street, Suite 700, San Francisco, CA 94103

Name: _____

Organization/Company: _____

Address: _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Thank you for your support of families of children and youth with special health care needs!

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Board of Directors Meeting
December 6, 2018

Special Joint Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee Update

Joint Member Advisory Committee (MAC) OneCare Connect Member Advisory Committee (OCC MAC), Provider Advisory Committee (PAC) Meeting and Whole-Child Model Family Advisory Committee (WCM FAC) scheduled for November 13, 2018

Nine (9) MAC members, six (6) OCC MAC Members, seven (7) PAC members and five (5) WCM FAC Members attended the November 13, 2018 Joint meeting of the Advisory Committees. While a quorum of the MAC was in attendance, OCC MAC, PAC and WCM FAC did not reach quorum.

Michael Schrader, Chief Executive Officer, introduced David Ramirez, M.D., as CalOptima's new Chief Medical Officer. Mr. Schrader reported the Department of Health Care Services (DHCS) announced its intention to implement the Whole-Child Model (WCM) in three phases, with CalOptima's transition taking place in Phase 3 beginning on July 1, 2019, six months later than originally planned. CalOptima is expected to receive the official notification on Friday, November 14, 2018, and all committees will be officially notified once the letter has been received.

Candice Gomez, Executive Director, Program Implementation, provided a verbal update on recent activities related to the WCM, including that notices will be sent out to impacted members after CalOptima receives official notice of the delay in implementation. Ms. Gomez also provided an update on the recent WCM family events that were recently held and well attended.

PAC Member, Junie Lazo-Pearson. Ph.D., BCBA-D, provided a presentation on Applied Behavioral Analysis (ABA) and the importance of early intervention.

MAC Chair Molnar provided an update on the Board's response to the directives on the Delivery System Request for Proposal and the Auto-Assignment Limits for the CalOptima Community Network that were provided by the MAC and the PAC at the November 1, 2018 Board meeting.

Members of the Advisory Committees thank the Board for the opportunity to provide this update.

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A Public Agency

CalOptima

Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting

December 6, 2018

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

November 13, 2018

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: November Board of Directors Report

While a flurry of campaign activity preceded the midterm elections on November 6, October was a fairly quiet month in Congress. The House was in recess the entire month, while the Senate adjourned on October 11 after wrapping up work on several judicial nominations. With the elections behind us, Congress will have just a few weeks to complete work on appropriations and other agenda items before the start of the 116th Congress in January. The new session will see Democrats in control of the House, with Republicans holding their majority in the Senate.

Lame Duck Outlook

There are a number of agenda items the 115th Congress may look to address during the "lame duck" period before the end of the year. With Democrats taking over the House in January, they may be less willing to compromise of end-of-year legislation. The remaining appropriations fights will be especially contentious. Negotiations over the Department of Homeland Security spending bill are expected to involve a heated debate over President Trump's insistence that Congress include greater funding for his proposed border wall, which Democrats oppose. The current continuing resolution (CR) provides funding for the remaining federal agencies through December 7. It is likely that another short-term CR will be needed in early December to allow more time for the funding debate to reach a conclusion.

In any case, Medicaid would be unaffected by any government shutdown in December. The Fiscal Year (FY) 2019 Labor-HHS appropriations bill was enacted on September 28 and includes federal Medicaid funding through the first quarter of 2020. Moreover, states are entitled to federal Medicaid payments under statute, and they would ultimately be reimbursed in the case of any lapse in funding.

MedPAC Session on D-SNPs

On November 1, the Medicare Payment Advisory Commission (MedPAC) held a public meeting session titled, "Promoting greater Medicare-Medicaid integration in dual-eligible special needs plans." Staff presented on the challenge of achieving greater integration for beneficiaries enrolled in dual eligible special needs plans (D-SNPs), the most widely used type of integrated plan. There are 381 D-SNPs nationwide, which enroll about 2 million dual eligibles. For most of these

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plans the requirements for Medicaid integration are fairly minimal, though fully integrated D-SNPs (FIDE SNPs) must meet higher standards for integration. Staff also explained that Medicaid spending for dual eligibles is largely for long-term services and supports (LTSS).

One barrier to integration is that that about 40 percent of D-SNP enrollees are in plans without LTSS contracts. Another issue is misaligned enrollment, where a plan sponsor has a companion LTSS plan but the beneficiary is only enrolled in the D-SNP. Finally, many dual eligibles receive only a partial Medicaid benefit. In these cases, there may not be many services to integrate. Staff asked the commissioners to consider whether D-SNP enrollment should be limited to full-benefit dual eligibles; whether D-SNPs should be required to have MLTSS contracts; whether D-SNPs should be required to use aligned enrollment; and whether the Centers for Medicare and Medicaid Services (CMS) should have the authority to prevent the entry of "look-alike" MA plans that target dual eligibles.

Several commissioners noted the complexity of these issues and expressed the need for an informational chapter in the Commission's next report. Commissioner David Grabowski called for moving more plans toward the FIDE SNP model while Commissioner Pat Wang struck a more cautious tone, stating that D-SNPs have value even when they are not providing LTSS. Commissioner Kathy Buto added that while the issue of Medicare-Medicaid integration is complex, it is important for MedPAC to continue to scrutinize the matter because dual eligibles account for a large share of costs for both programs.

MACPAC Session on Public Charge Proposed Rule

On October 25, the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public meeting session titled, "Proposed Rule: Inadmissibility on Public Charge Grounds." The session examined a new proposed rule from the Department of Health and Human Services (HHS) that would modify the definition of a public charge to include those who receive benefits such as Medicaid. As a result, immigrants who receive Medicaid benefits could be denied green cards. Staff identified several potential effects of the proposed rule on Medicaid beneficiaries, noting it could prompt eligible individuals to disenroll out of concern for their immigration status. Staff also discussed the possibility of increases in uncompensated care and raised concern about the administrative burden associated with tracking the use of public benefits.

A number of commissioners identified the need for further clarification on the rule and how it would affect those applying for Medicaid coverage. Chairwoman Penny Thompson also called for more information on how the proposed rule would impact the safety net system.

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Public comments on the proposed rule are due December 10, and a final rule is not expected before sometime in 2019.

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Final Report (as of writing at 5 PM EST on November 19, 2018)

2018 Midterm Election Overview

In the 115th Congress, Republicans hold the House majority with 235 seats and the Democrats have 193 seats, with seven vacancies headed into the election. As most political pundits projected, the Democrats came out on top in the House elections. As of November 19, Democrats have flipped 40 seats currently held by Republicans while the GOP captured 3 seats from Democrats, leaving Democrats with a net gain of 37 thus far. Democrats only needed a couple dozen seats to retake the majority, and thus, when the 116th Congress convenes in January, the Democratic Party will hold over 230 seats, returning the party to power for the first time in eight years. Both parties could see their seat totals rise as victors in 5 seats remain undetermined.

Unlike the House, where all 435 seats were up for reelection, only 35 seats, roughly a third, were in cycle in the Senate this year. Going into the election, Republicans held a slim majority with 51 seats, and Democrats and Democratic-caucusing Independents held 49 seats. As of writing, the GOP has beaten 3 sitting Democratic senators in Indiana, Missouri, and North Dakota. They also held on to competitive seats in Tennessee and Texas. Republicans lost seats in Nevada and Arizona, bringing their current total for the new Congress back to 51. Two Senate races remain uncalled, leaving President Trump's Senate contingent with the possibility of picking up more seats. In Florida, Republican Gov. Rick Scott is still expected to come out on top following a recount. In Mississippi, the special U.S. Senate election will proceed to a runoff on November 27, and Republicans are favored to hold onto the seat.

On the gubernatorial side, Democrats were successful in picking up 7 governor's mansions now held by Republicans in Illinois, Kansas, Maine, Michigan, Nevada, New Mexico, and Wisconsin, bringing their total to 23. While Republicans did not pick up any governorships, they still currently lead Democrats with 25 state chief executives. The Florida gubernatorial race remains uncalled.

Orange County Congressional Delegation

Democrats swept all seven U.S. House seats in Orange County during the midterm elections, marking the first time the entire county has gone blue in more than 80 years. Although several races initially looked positive for House Republicans on election night, and were too close to call for several days thereafter, late vote counts favored Democrats.

In the House:

- Rep. Linda Sanchez (D) won 67.4% of the vote against Republican challenger Ryan Downing in the race for California's 38th Congressional District.
- Democratic candidate Gil Cisneros will fill retiring Rep. Ed Royce's (R) seat in the 39th Congressional District, narrowly beating Republican Young Kim, who conceded on Sunday.

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- In the race for California's 45th Congressional District, Democrat Katie Porter defeated incumbent Republican Rep. Mimi Walters with just over 51% of the vote. Rep. Walters conceded on Friday afternoon.
- Rep. Lou Correa (D) won another term representing California's 46th Congressional District, beating Republican Russell Lambert by 30 percentage points.
- Rep. Alan Lowenthal (D) also easily held on to his seat, beating Republican John Briscoe in the race for California's 47th Congressional District.
- In California's 48th Congressional District, Republican incumbent Rep. Dana Rohrabacher lost to Democrat Harley Rouda, who garnered 52 percent of the vote.
- Finally, Democrat Mike Levin beat out Republican Diane Harkey to fill retiring Rep. Darrell Issa's (R) seat in the 49th Congressional District.

In the Senate, the California delegation is status quo with Sen. Diane Feinstein (D) winning re-election over fellow Democrat State Sen. Kevin de Leon, and freshman Sen. Kamala Harris (D) not up for re-election.

A Look at 2020

While Republicans had a plum map in 2018, the tables will turn in 2020, a presidential election year. Whereas Republicans in 2018 only had to defend 9 seats compared to Democrats 24 seats, in 2020, the GOP will be forced to defend 20 (21 if the Republican prevails in the upcoming Mississippi runoff election) while Democrats will only have 12 seats in cycle.

Where the Senate Republicans seats are up is also of importance. Several GOP Senators will be running in what are considered highly competitive swing states. Republicans representing six states—Arizona, Colorado, Georgia, Iowa, Maine, and North Carolina—are likely to face spirited challenges. Additionally, Democrats are likely once again to target Senate Majority Leader Mitch McConnell (R-KY), attempting to recruit a candidate that will make the race competitive in a conservative state.

Of those competitive states, all except Colorado broke for President Trump in 2016, although by slim margins. Maine gave a single electoral vote to President Trump while giving the rest to Hillary Clinton. Looking further back to 2012, President Obama carried Colorado, Maine, and Iowa, while Arizona, Georgia, and North Carolina voted for Mitt Romney.

Though the map is much more generous to Democrats in 2020 compared to 2018, they will have to defend a couple of seats that are likely to draw a challenge. The Alabama Senate seat currently held by Senator Doug Jones will be at the top of the Republicans' priority list. The GOP also is likely to invest heavily in races in New Hampshire and Virginia.

As it pertains to governorships, 3 southern states—Kentucky, Louisiana, and Mississippi—will hold statewide elections in 2019. All three states handily voted for President Trump and Mitt Romney. Deep-red Louisiana currently has a Democratic governor that will likely field a strong

GOP challenger, and the Kentucky gubernatorial race is already shaping up to be a competitive race.

In 2020, 11 states will hold gubernatorial elections, the Trump-Romney states of Montana and North Carolina both of which have Democratic governors. Meanwhile, Republican incumbents will be eligible for reelection in Vermont, a deeply Democratic state, and New Hampshire, which will be a target of investment from presidential campaigns.

Lame Duck Preview

With the midterm elections in the rearview mirror, the 115th Congress is officially a lame duck. Notwithstanding this status, there remain plenty of agenda items that the legislature can and must address before the end of the Congress in December, and with Democrats soon to control the U.S. House of Representatives, there could be a shift in how lawmakers address these issues. With Democrats taking over the House majority in January, they are likely to be less willing to compromise on end-of-year legislation given the ability to have a greater influence by punting key issues to the 116th Congress. At the same time, Democrats may be looking to clear the decks on some legislative issues to start 2019 with a clean slate and opportunity to move forward their own policy agenda.

Leadership Elections

One of the early decisions to be made for the 116th Congress is who will leader the parties in each chamber. On November 14, three of the four party conferences chose their leadership team. In the House, Rep. Kevin McCarthy (R-CA) defeated Rep. Jim Jordan (R-CA) to become the next Republican Minority Leader, replacing retiring Speaker Paul Ryan (R-WI) as the head of the House GOP. The House Democratic Caucus will choose its leaders on November 28. Members of the current leadership team will campaign aggressively in order to maintain their seat at the table. A number of members are waiting in the wings before mounting any challenges so that they can assess the post-election landscape. Further announcements for a number of leadership races are likely. At present, House Democratic Leader Nancy Pelosi (D-CA) is likely to be elected Speaker of the House when the new Congress convenes in January. A caucus vote is set for November 28, and Leader Pelosi is expected to earn a majority vote but is facing pressure to step aside from a small group of Democrats seeking change in leadership.

On the Senate side, the Senate Republican Conference elected to keep Majority Leader Mitch McConnell (R-KY) as its leader on November 14. Senate Majority Whip John Cornyn (R-TX) is term-limited in his leadership post, but is expected to continue to sit at the leadership table in a counsel role appointed by Leader McConnell. The current members of the Senate GOP leadership moved up the leadership ladder, with Sen. John Thune (R-SD) becoming the new Senate Majority Whip. On the same day, Senate Democrats reelected Senate Minority Leader Chuck Schumer (D-NY) to leader them in the next congress. The rest of the Senate Democratic leadership team also largely remained the same.

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Appropriations

One of the great bipartisan achievements of this Congress was the passage of the most appropriations bills on time in over two decades. Despite historic progress on appropriations before the September 30 deadline earlier this fall, the remaining spending fights in the lame duck will be contentious. One of the seven remaining appropriations bills provides funding for the Department of Homeland Security, which is expected to lead to a heated debate over President Trump's insistence that Congress include funding for his proposed border wall, which Democrats oppose. The current CR provides funding for the remaining federal agencies through December 7. It is likely that another short-term CR will be needed in early December to allow more time for the funding debate to reach a conclusion. If members cannot agree on the remaining spending bills before the holidays, a third CR may be needed to extend the debate into 2019. The incoming House Democratic majority may prefer this route, as Democrats will have more leverage when they take control of the lower chamber in January.

Tax Policy

A larger end-of-the-year package may also include a tax component. The size and scope of the tax package will be determined by a political calculus on both sides regarding the urgency of various provisions and the overall mix of the package in terms of Republican and Democratic priorities. Since the Tax Cuts and Jobs Act was passed in December 2017, a number of technical fixes have surfaced that may be able to find a home in the lame duck. The Senate Finance and House Ways and Means Committees have each worked on a package of fixes and improvements for retirement plans that may see conclusion in the lame duck. In addition, some of the provisions referred to as "tax extenders" technically expired on December 30, 2017, but Congress has a history of retroactively renewing these provisions, so they will be part of the larger negotiation on a possible tax package. However, with the enactment of a long-term FAA authorization bill in early October, that eliminated a "must pass" tax vehicle for the lame duck, slightly reducing the odds of a tax package coming together in December.

Other possible tax-related items for the package include IRS reform, Health Savings Account modernization measures, and possibly a delay of Affordable Care Act taxes like the health insurance tax.

With Democrats poised to regain control of the House, they may prefer waiting on some of these items until they take the majority in January, but that determination will be made based on the tenor and scope of the negotiations.

Other Items

There are a host of other issues that Congress may address in the lame duck. Again, it all relies on whether Democrats are willing to participate in negotiations and deal making or prefer to wait until the 116th Congress. Other issues that Congress could address include:

- Flood insurance reauthorization
- Farm Bill conference report

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- JOBS and Investor Confidence Act (a.k.a. JOBS Act 3.0)
- Medicare Part D coverage gap fix for pharmaceutical companies
- Disaster relief
- Action on recommendations from the Joint Select Committees on Solvency of Multiemployer Pension Plans and Budget and Appropriations Process Reform

Health Care Issues in the 116th Congress

With Democrats in control of the House, the 116th Congress is expected to sharpen its focus on health care access and consumer costs in 2019. In particular, a Democratic House is likely to advance legislation to address drug costs, though it remains unclear whether Democrats will agree to band together with President Trump to advance a unified bipartisan drug pricing agenda.

The Administration's latest drug pricing proposal, the "International Pricing Index Model," would move payment levels for physician-administered drugs to payment levels based on international prices over a five-year period, would apply to 50 percent of the country, and would cover most drugs in Medicare Part B. Pharmaceutical manufacturers, physician groups and other stakeholders already have weighed in with their concerns about the initiative, raising questions about whether it will be implemented in its current form.

Even if President Trump and House Democrats agree on a drug pricing plan, Senate Republicans are likely to have a different view and approach. One area of recent bipartisan focus has been the 340B Drug Pricing Program, with calls for reform from both sides of the aisle. Targeted legislation to reform the 340B Program could be considered in the next Congress; however, proposals to scale back eligibility or impose a moratorium on enrollment are unlikely to gain traction in a Democratic House. Another possible area of bipartisan support on health care costs is legislation to address billing for unexpected charges to consumers through balance billing of medical expenses for which they lack coverage.

Republican efforts to repeal the Affordable Care Act (ACA) featured prominently in Democrats' campaign messaging this cycle. The new Democratic majority in the House may consider legislation to shore up the health law and stabilize insurance markets, as well as legislation to protect individuals with pre-existing conditions, while courts consider a challenge to the ACA filed by 20 Republican attorneys general.

In addition, Democrats have made a substantial political bet on an expansion of Medicare. While we do not anticipate seeing "Medicare for All" legislation move through the next Congress, it will be an issue of focus in Committee hearings and certainly debate in the House.

Democrats' success in securing a majority in the House was also accompanied by similar electoral victories in many states. As a result of successful ballot initiatives (in Idaho, Nebraska

and Utah) and gubernatorial elections (in Kansas, Wisconsin and Maine), a number of additional states now are expected to expand coverage under Medicaid. By contrast, in other states where unsuccessful Democratic candidates for governor made it a platform issue (*e.g.,* Florida, Georgia and Tennessee), Medicaid expansion will remain off the table in the near term.

The next Congress will also need to address a number of health-related expiring legislative authorities in 2019, including the delay of Medicaid cuts to Disproportionate Share Hospitals until September 30, 2019, and suspension of the Affordable Care Act's medical device and health insurance taxes until December 31, 2019.

Finally, during anticipated negotiations over a budget caps deal and expiration of the debt ceiling suspension on March 1, 2019, health care provider payments may be at risk as Members look for "pay-fors" to offset the cost of the package.

Akin Gump Report
to CalOptima Board of Directors

Geoff Verhoff, Policy Advisor

Eli Tomar, Counsel

December 6, 2018

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2018 Midterm Elections

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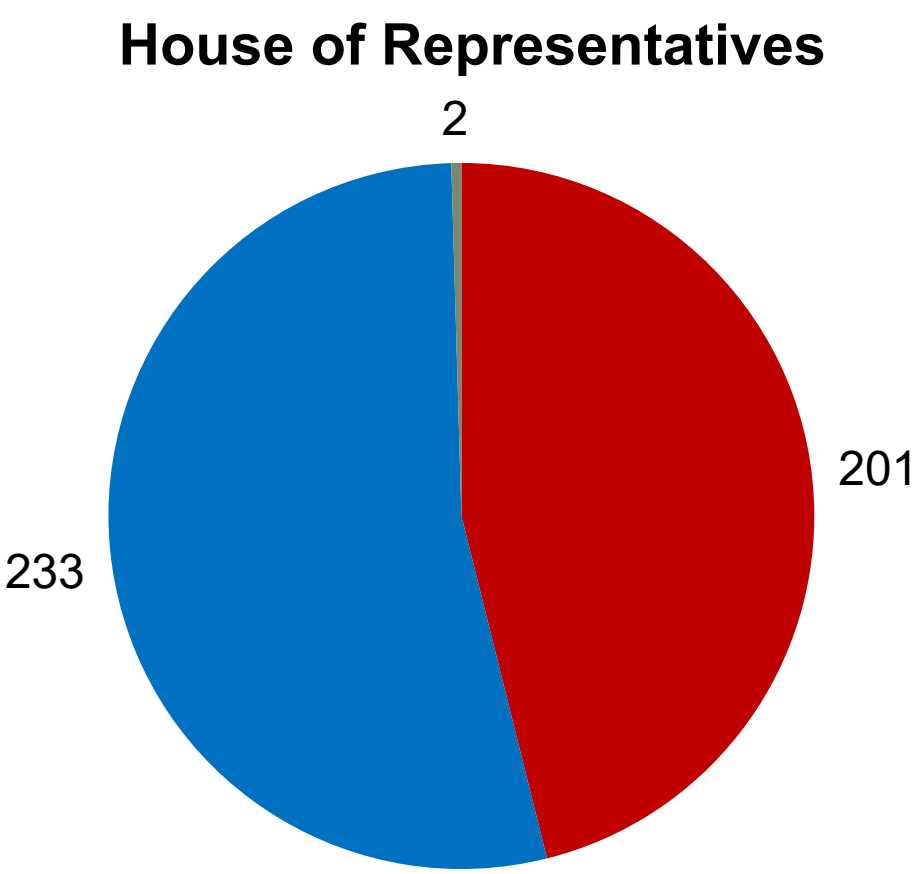
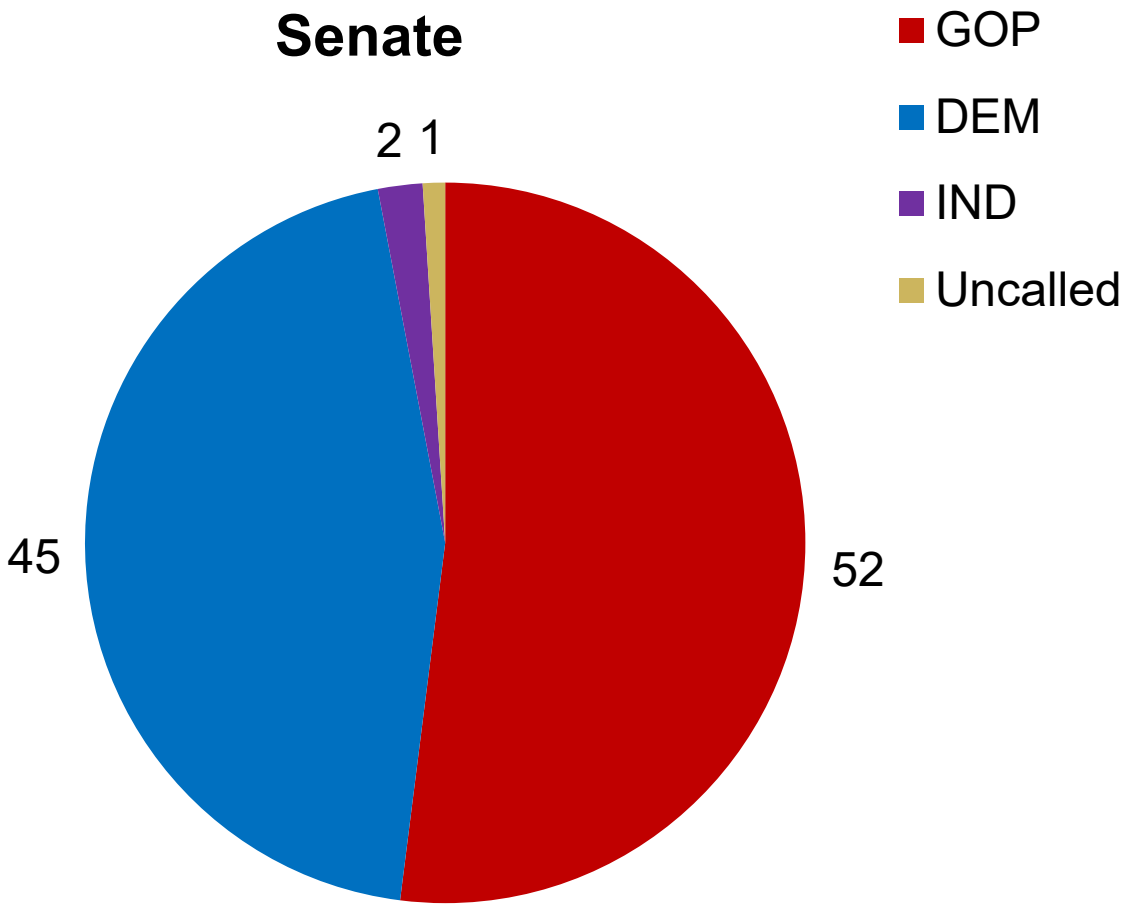
Image: CNN

Make Up of the 116th Congress*





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*As projected by CNN (as of Nov. 26)

Orange County Delegation—Now All Democratic

House District	Incumbent	2018 Victor
California 38	Linda Sanchez (D)	Linda Sanchez (D)
California 39	Ed Royce (R)*	Gil Cisneros (D)
California 45	Mimi Walters (R)	Katie Porter (D)
California 46	Lou Correa (D)	Lou Correa (D)
California 47	Alan Lowenthal (D)	Alan Lowenthal (D)
California 48	Dana Rohrabacher (R)	Harley Rouda (D)
California 49	Darrell Issa (R)*	Mike Levin (D)

Senate	Incumbent	2018 Victor
California	Diane Feinstein (D)	Diane Feinstein (D)
	Kamala Harris (D)	(not up for re-election)

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*Retired

Health Policy Outlook

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Health Care Legislative Outlook

- Health care costs
  - Democrats efforts to bring down prescription drug costs, a potential area of cooperation with the Trump Administration
  - Bipartisan support for surprise medical billing legislation
- ACA-related legislation
  - Market stabilization, protection for pre-existing conditions
  - Delays or reforms to ACA taxes
- Entitlement reform
  - “Medicare for All” may be a focus of Committee hearings and broader policy debate
  - Changes to Medicaid may also be discussed, but major financing overhaul (e.g., block granting) unlikely to advance

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Health Care Regulatory Outlook

- Trump Administration expected to continue deregulatory agenda
  - Increased flexibility for states around Medicaid (e.g., work requirements) and state-based health insurance exchanges (e.g., 1332 Waivers)
- Possible implementation of "Public Charge" rule
  - Potentially significant impact on Medicaid and Children's Health Insurance Program (CHIP)
- Medicaid/CHIP Managed Care rulemaking
- Additional drug pricing regulations
- Incremental Medicaid reform efforts ("entitlement reform" by regulation)

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2018 General Election Report
By Mike Robson, Trent Smith, Don Gilbert, and Jason Ikerd
November 9, 2018

Overview

The television and radio ads have stopped and our mailboxes are less full -- the 2018 midterm/gubernatorial elections are over. However, ballots are still being counted and the outcome of many races in California are still to be decided in the coming weeks. There are 4.5 million late and provisional ballots that must be counted and sent to the Secretary of State by December 7.

As expected, Democrats won every significant statewide office on election night with two statewide elections that are still too close to call – Insurance Commissioner and Secretary of State. Though, California's election results should not be construed as part of a "Blue Wave". Instead, the election results reflect an ongoing multi-election decline in Republican party electoral success throughout California - all rooted in the fact that Republican party registration in California continues to decline. On October 22, the Secretary of State reported that No Party Preference (NPP) voters comprised 27 percent of the electorate while the Republicans comprised only 24.5 percent. In fact, 49 of the 80 Assembly Districts have a higher percentage of NPP voters than those who identified as Republican. The Republican Party decline does not mean people are turning to the Democratic Party. Democrat registration has declined slightly over the years and there is one Assembly District in California where the NPP numbers are higher than the Democrats.

Statewide Offices

Governor

As expected, Gavin Newsom was elected Governor by a wide margin of nearly 20 points. As the former Mayor of a big city, Governor-elect Newsom has experience balancing a budget, managing a bureaucracy, negotiating with public employees, and advancing a public policy agenda. In the coming weeks, we will learn more about how the Governor-elect will use that experience when he announces a policy agenda and a proposed budget for the 2019-2020 fiscal year. In the near-term all eyes will be focused on who he brings to his staff and cabinet to help govern the state.

Insurance Commissioner

As noted above, the race for Insurance Commissioner is still too close to call. As of November 8, Senator Ricardo Lara (D) was leading the No Party Preference candidate, Steve Poizner by approximately 400,000. The Poizner candidacy was significant in that he made the November General election without being in either party.

Superintendent of Public Instruction
This race between two Democrats was the most expensive race between candidates on the ballot. It is viewed as a proxy fight between the Charter School movement who supported Marshall Tuck and the California Teachers Association who supported Tony Thurmond and is relevant to the progressive and moderate split in the Democratic party.

Legislature

Going into the election, the Democrats in the Assembly enjoyed a 55-vote supermajority while the Democrats in the Senate held 26 votes and needed one seat to gain the same two-thirds supermajority advantage. However, as noted in our pre-election report, there is not unanimity of thought in the Democratic Caucuses, which is evident in the split between moderate/traditional Democrats and the more progressive Democrat. There were two Assembly races and a Senate race where the Progressive Democrat lost to a more Moderate Democrat. Therefore, while a two-thirds majority makes it possible for the party in power to pass general tax increases, Constitutional Amendments, and make changes to the rules of the Legislature, it is not certain that it will happen.

Assembly
At this time, there are certain to be 56 seats held by Assembly Democrats, with three and maybe four races where the election-day outcome is not certain. In those races, we believe the late processed ballots will trend in the Democrat candidate's favor. If that holds true, there is potential for 59 or 60 Democrats to be sworn in to the Assembly on December 3, 2018.

Senate
In the State Senate, the election outcomes are more certain. Senate Democrats will hold 28 seats when Senators are sworn-in on December 3. However, if Senator Lara wins his race for Insurance Commissioner, the numbers will drop to 27 and a Special Election will be held to replace him.

Ballot Measures

There are no close elections pertaining to statewide ballot measures. As is typical, campaigns for and against ballot measures generated the most mail, television and radio play with spending in the hundreds of millions of dollars. The Initiative and Referendum process, commonly called Direct Democracy, exists to allow citizen to act on policy when the Legislature does not. Interestingly, in this election cycle, the outcomes of the ballot measures only served to validate previous actions by the Legislature, as measures placed on the ballot by the Legislature passed, while measures to circumvent legislative action failed.

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Notable ballot measures include:

Proposition 6 Gas Tax Repeal -- Failed
Proposition 6, aimed to repeal the legislatively approved increase in the gas tax and vehicle fees, was defeated. This was a significant development given the fact that the proponents early and easily qualified the measure through signatures. However, the repeal campaign lacked significant financial resources to sustain a campaign and really lost momentum after the successful recall of a State Senator who voted for it. The opposition campaign, comprised of a coalition of labor, construction, transit, and local governments ran an effective campaign and defeated Proposition 6 on a 55.2 percent to 44.8 percent margin. Despite this sound defeat, the proponents have vowed to continue efforts to recall legislators who voted for the original legislation and to continue their efforts through litigation.

Proposition 8 Dialysis Clinics – Failed
This ballot measure is notable for the fact that it had the largest amount of money spent on the campaign opposition, with more than $100 million being spent. Proposition 8 was placed on the ballot by labor unions who have been battling over organizing and working conditions in dialysis clinics for years. A bill on this subject also failed to pass the Legislature.

Proposition 10 Rent Control – Failed
This measure would repeal existing state law that restricts local governments from enacting strict rent control measures on landlords and property owners. This measure was placed on the ballot by labor unions in response to the fact that the California Legislature refused to advance a similar bill.

Proposition 1 Housing Bond -- Passed
Authorizes $4 billion in general obligation bonds for affordable housing programs for low-income residents, veterans, farmworkers, manufactured and mobile homes, infill, and transit-oriented housing. This measure was placed on the ballot by the Legislature.

2019 Legislative Outlook
The new Legislature will be sworn-in on December 3 while Governor Newsom will take office on January 7, 2019, and a proposed State Budget will be released on January 10, 2019.

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2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 6157 Granger	**Health Human and Services (HHS) Appropriations/ Previous Spending Levels Continued:** Funds the Department of Health and Human Services (HHS) for fiscal year (FY) 2019, along with the Departments of Defense, Labor, and Education. This bill would provide $90.5 billion in discretionary funding for HHS programs and agencies in FY 2019 – a $2.3 billion increase over current funding levels. It is important to note that although Medicare and Medicaid are administered by HHS, they are not funded through the annual appropriations process. Like other entitlement programs, Medicare and Medicaid are supported by mandatory funding that flows automatically without requiring annual congressional approval. In addition to providing appropriations for HHS, Labor, Education and Defense programs, the bill includes language that would continue current spending levels through December 7 for any federal agencies and programs that have not received an appropriation by October 1, the beginning of the Federal Fiscal Year.	**09/28/2018** Signed into law **09/18/2018** Senate agreed to Conference Committee bill text **09/13/2018** Conference Committee agreed on text **08/23/2018** Passed Senate, with amendments **06/28/2018** Passed House of Representatives **06/20/2018** Introduced	Watch
H.R. 3325 Barton	**ACE Kids Act:** Would provide state Medicaid programs the option of providing medical assistance through a "health home" for children with medically complex conditions. State Medicaid agencies, like the Department of Health Care Services (DHCS), would have the option of submitting a state plan amendment to the Centers for Medicare & Medicaid Services (CMS) to participate in this program. Participating states would receive a higher Federal Medical Assistance Percentage (FMAP) for each child participating in this program. This bill would gives states the option to pay designated providers, such as children's hospitals, directly for the care of these children, which could result in these children being carved out of managed care.	**09/13/2018** Passed House Committee on Energy and Commerce **07/20/2018** Introduced	Watch CalOptima provided feedback to bill author
H.R. 6 Walden	**Opioids – Prescription Controls, Education/Prevention, and Provider Incentives:** The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act is a bipartisan effort in response to the national opioid crisis. The bill includes a broad range of provisions from multiple bills that were previously advanced through the House Energy and Commerce and Ways and Means Committees. There are several provisions relevant to the Medicaid and Medicare programs, including proposals to implement controls on pharmaceuticals to prevent inappropriate dispensation of opioids, expand access to effective addiction treatment, increase opioid misuse education and prevention efforts, and provide incentives to discourage physicians from over prescribing opioids.	**10/24/18** Signed into law **10/03/2018** Passed Senate and sent to the President **06/22/2018** Passed the House **06/13/2018** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 6561 Walorski	**Programs of All-Inclusive Care for the Elderly (PACE) Final Rule:** Would direct the Secretary of Health and Human Services (HHS) to release the final PACE rule no later than December 31, 2018. The final rule would implement the first regulatory update to PACE regulations in more than ten years. The proposed changes include allowing PACE organizations (POs) to, (1) include community physicians as part of their hallmark interdisciplinary teams (IDTs); (2) use nurse practitioners and physician assistants as primary care providers; (3) provide services in settings other than the PACE Center, and; (4) configure the IDT to meet the needs of individual participants. Taken together these changes are likely to enable POs to accommodate more participants and expand their programs without compromising quality of care. CalOptima PACE has been an early adopter of many of these PACE innovations, applying for CMS exemptions to utilize community-based physicians, nurse practitioners, and the Alternative Care Setting (ACS) model to deliver PACE care outside of the PACE center.	**09/17/2018** Referred to Senate Committee on Finance **09/10/2018** Passed House, ordered to Senate **07/26/2018** Introduced and referred to the Committee on Ways and Means, and to the Committee on Energy and Commerce	Watch CalOptima provided feedback to members of OC congressional delegation
H.R. 6082 Mullin	**Confidentiality Regulations:** Would align the federal Confidentiality of Substance Use Disorder Patient Records regulations (42 USC 290dd-2 and 42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) as they relate to the disclosure of substance use disorder (SUD) treatment. This bill would authorize the disclosure of SUD patient records to a covered entity, such as CalOptima, for treatment, payment, and health care operations without a patient's written consent, which is required under current law. This change would simplify the process of coordinating behavioral and physical health services by allowing health plans and providers treating the same patient to access their member's SUD treatment information.	**06/21/2018** Referred to the Senate Committee on Health, Education, Labor, and Pensions **06/13/2018** Introduced	Watch CalOptima provided feedback to members of OC congressional delegation
H.R. 4957 Sanchez	**Improving Alzheimer's Care:** Among other provisions, would establish Alzheimer's models of care based on a comprehensive continuum of care, similar to care delivery in the Program of All-Inclusive Care for the Elderly (PACE).	**02/13/2018** Referred to House Committee on Ways and Means Subcommittee on Health **02/07/2018** Introduced in the House	Watch
H.R. 1625 Royce	**FY 2018 Federal Budget/Omnibus Spending Bill:** Funds the federal government for the remainder of the 2018 budget year, through September 30. The bill includes: • $1.3 trillion in overall spending • $403 billion in Medicaid spending (an increase of $25 billion or 7 percent, accounting for 1.8 million more Medicaid beneficiaries and an increase in opioid related funding, among other factors) • $3.6 billion for opioid-addiction and mental health services (an increase of $2.55 billion or 244 percent) Of note, the bill did not include any stabilization measures for the individual market, such as the cost-sharing reduction payments or a federal reinsurance program.	**03/22/2018** Signed into law	Watch

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 1892 Larson	**FY 2018 Federal Budget/Previous Spending Levels Continued:** • Establishes a two-year budget framework and continues current federal spending levels until March 23, 2018. • Permanently reauthorizes Dual Eligible Special Needs Plans (including CalOptima's OneCare program). • Extends reauthorization for the Children's Health Insurance Program (CHIP) until 2027. • Extends the Community Health Center Fund (CHCF) for two years.	**02/09/2018** Signed into law	CalOptima sent letter of support for CHIP, D-SNP and CHCF
H.R. 195 Russell	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending until February 8, 2018. Also authorizes CHIP funding for six years, until 2023, and gradually phases down the enhanced federal matching rate – 88/12 federal/state, to the regular CHIP rate – 65/35 federal/state in FY 2021.	**01/22/2018** Signed into law	CalOptima sent letter of support for CHIP
H.R. 1 Brady	**Tax Cuts and Jobs Act:** Amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. It also eliminates the Affordable Care Act's (ACA) individual mandate, effective December 31, 2018.	**12/22/2017** Signed into law	Watch
H.R. 3922 Walden	**Five Year CHIP Re-authorization:** Would have extended federal CHIP funding, which expired on September 30, 2017, for five years. Would have retained the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduced it by 11.5 percent for one year (76.5/23.5), and reverted to pre-ACA levels for two years (65/35). Also included spending offsets such as increasing Medicare premiums for beneficiaries who make more than $500,000 annually, requiring Medicaid beneficiaries to report lottery winnings as income, and decreasing funding for the ACA-enacted Prevention and Public Health Fund. Of note, H.R. 1892, referenced above, extends federal CHIP funding until 2027, and was signed into law on 02/09/2018.	**11/03/2017** Passed House, ordered to Senate **02/09/2018** 10-year reauthorization of CHIP funding included as part of H.R. 1892 (Larson)	CalOptima sent letter of support for CHIP
H. Concurrent Resolution 71 Black	**FY 2018 Budget Resolution:** The annual budget resolution sets the budgetary framework for the upcoming fiscal year and allows Congress to pass reconciliation legislation, which requires 51 votes to pass the Senate rather than the normal 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	**10/26/2017** Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch
H.R. 601 Lowey	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending ($1.24 trillion overall) and raises the debt ceiling through December 8, 2017. Ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately $65 billion per year. Mandatory spending ($2.54 trillion overall) for programs such as Medicare and Medicaid continues at previous levels, less a small percentage, as required by the terms of the Budget Control Act of 2011.	**09/08/2017** Signed into law	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
Bipartisan Health Care Stabilization Act of 2017 Alexander/ Murray	**Marketplace Stabilization:** Would fund cost-sharing reductions (CSRs) – federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the federal poverty level (FPL) who have a "silver" level plan – through 2019. Also, would increase flexibility and streamline the state waiver approval process, among other changes. While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to "churn" between Medicaid and the individual market.	**10/19/2017** Draft bill text released	Watch
S. 1804 Sanders	**Medicare for All:** Would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, as well as most forms of private insurance, and enroll all eligible individuals into the new universal plan.	**09/13/2017** Referred to Senate Committee on Finance	Watch
H.R. 676 Ellison	**Medicare for All:** Similar to S. 1804, would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs as well as most forms of private insurance. The program would be funded via existing sources of government revenues for health care and by increasing personal income taxes on the top five percent of income earners, among other measures.	**01/24/2018** Referred to House Committee on Energy and Commerce, House Committee on Ways and Means, and the House Committee on Natural Resources	Watch

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 840 Mitchell	**Budget Act of 2018:** Funds the state government for the 2018-2019 fiscal year. The Medi-Cal allocation is $104.4 billion, including $23 billion general fund. The following allocations impact the Medi-Cal program: • Medi-Cal Expansion Population: $18.7 billion ($1.7 billion GF) • Coverage for children regardless of immigration status: $365.2 million ($287.7 million GF) • Breast and Cervical Cancer Treatment Coverage: $8.4 million GF • Supplemental Provider Payment: $710 million (from Proposition 56) *The Budget Act is the predominant method by which appropriations are made to fund the state government. A budget bill is introduced by January 10 and the Legislature is required to pass the budget bill by June 15. The Budget Bill becomes the Budget Act upon the Governor's signature.*	**06/27/2018** Signed into law by the Governor	Watch
SB 856 Senate Budget Committee	**Junior Budget Bill:** Makes changes and corrections to the Budget Act of 2018, such as appropriating Proposition 56 tobacco tax revenue and related federal funds for Medi-Cal, among other provisions. This bill allocates up to $500 million for supplemental payments for physician services and directs the Department of Health Care Services (DHCS) to develop the methodology for distributing these payments as well as post the proposed payment structure on its website by September 30, 2018. *The Junior Budget Bill is the method by which amendments are made to the chaptered Budget Act.*	**06/27/2018** Signed into law by the Governor	Watch
SB 849 Senate Budget Committee	**Medi-Cal Trailer Bill:** Budget trailer bill that makes appropriations related to Proposition 56 supplemental payments (in conjunction with SB 856) and creates a dental integration pilot program in San Mateo County (carving dental into managed care), among other provisions. *When budget changes proposed by the Governor require changes to existing law, the legislation introduces separate legislation, referred to as "trailer bills," which are heard concurrently with the Budget Bill.*	**06/27/2018** Signed into law by the Governor	Watch
SB 850 Senate Budget Committee	**Homeless Emergency Aid program and Orange County Shelter:** Establishes the Homeless Emergency Aid program to provide local governments with one-time flexible block grant funds to address their immediate homelessness challenges. The bill requires the Business, Consumer Services, and Housing Agency to allocate a total of $500 million among local governments, with funding allocated according to homeless point-in-time counts, proportionate share of total homeless population, as well as direct allocations to cities and counties with populations over 330,000. This bill also requires DHCS to allocate $5 million to the Bridges at Kraemer Place emergency shelter in Orange County to create a homeless navigation center.	**06/27/2018** Signed into law by the Governor	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
RN 1802014 Trailer Bill – 340B Drug Program	**340B Drug Purchasing Program:** Would prohibit the use of 340B discounted drugs in Medi-Cal starting July 1, 2019, pending approval from CMS. Section 340B of the Public Health Service Act allows certain hospitals and clinics to purchase pharmaceuticals at discounted prices. Federal and state agencies have found inconsistencies with the program's implementation. According to DHCS, these inconsistencies create a substantial administrative burden on the state. As such, the Department's proposed trailer bill language seeks to prohibit the use of 340B drugs in Medi-Cal. In the event that CMS does not grant the state permission to entirely exclude 340B drugs from Medi-Cal, the state will seek CMS approval for limiting the use of 340B drugs in Medi-Cal. Although this trailer bill language was not included in the final Budget deal, DHCS is likely to continue efforts to reform the 340B program through the regulatory process.	**05/15/2018** Heard in Senate Budget Subcommittee No. 3: Health and Human Services **01/16/2018** Trailer bill language published on the Department of Finance website	Watch CalOptima provided feedback as part of the CAHP and LHPC comment letters to DHCS
AB 2331 Weber	**Medi-Cal Eligibility Redetermination:** Would allow developmentally disabled individuals receiving services at regional centers to remain continuously eligible for Medi-Cal. Rather than the beneficiary being responsible for ensuring that annual redetermination is performed, counties will use information provided by the California Department of Developmental Services (DDS) and DHCS to ensure that they meet Medi-Cal eligibility criteria.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 1963 Waldron	**Opioids – Treatment:** Would increase provider reimbursement rates for Medication-Assisted Treatments (MAT). MAT requires that patients receive counseling, behavioral therapies, and recovery support services in combination with prescribed medication, such as buprenorphine/naloxone, methadone, buprenorphine, and naltrexone. These therapies have proven to be very effective in treating opioid addiction. There is a significant shortage of providers certified to administer MAT treatments. Depending on how the reimbursement structure is constructed, a rate increase could potentially help CalOptima expand access to MAT services in Orange County.	**05/25/2018** Held under submission in Assembly Appropriations Committee **01/30/2018** Introduced	Watch CalOptima provided feedback to the bill author
AB 2741 Burke	**Opioids – Supply Limit:** Would prohibit providers from prescribing more than a five-day opioid supply to a minor, except in the case of pain associated with cancer, palliative or hospice care, chronic pain, and emergency services and care; and require parental consent for opioid prescriptions.	**06/18/2018** Held in the Senate Business, Professions and Economic Development Committee at the request of the author **05/07/2018** Passed Assembly Floor and ordered to the Senate **02/16/2018** Introduced	Watch CalOptima provided feedback to the bill author

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 1998 Rodriguez	**Opioids – Prescription Controls:** Would institute more stringent prescription controls related to opioids, including limiting opioid prescriptions to amounts sufficient for not more than three days. *Bills which are determined to exceed a cost impact of $150,000 are placed on "suspense file" to be heard by the Appropriations Committees at the suspense file hearing towards the end of the legislative cycle. If the bill moves out of the suspense file, it proceeds to the floor for a vote while bills held on suspense die.*	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/01/2018** Introduced	Watch
AB 2430 Arambula	**Medi-Cal Eligibility for Seniors:** Would adjust the income threshold for seniors eligible for Medi-Cal under the Aged and Disabled Federal Poverty Level Program from 123 percent FPL to 138 percent FPL, bringing it in line with other Medi-Cal programs for adult beneficiaries. Currently, seniors with income levels above 123 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as "share of cost." Under share of cost, beneficiaries must take full responsibility for health care expenses up to a predetermined amount (share of cost) for the month in which they receive services. Once they meet their share of cost, Medi-Cal pays for any additional covered services for that month. This bill aims to ensure that low-income seniors have access to Medi-Cal at the same income level as most other adult beneficiaries, without incurring extra financial burdens.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/29/2018** Passed Assembly Floor and ordered to the Senate **02/14/2018** Introduced	Watch CAHP: Support LHPC: Support
SB 945 Atkins	**Breast and Cervical Cancer Treatment Program (BCCTP):** Would remove the 18 to 24-month cap on coverage under the state Breast and Cervical Cancer Treatment Program (BCCTP), which would allow members to remain in the program and CalOptima to continue receiving adequate reimbursement for the duration of their treatment. Currently, DHCS administers BCCTP, which provides cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer that meet certain screening and income eligibility criteria. Currently, for individuals enrolled in the state BCCTP program, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Provisions from SB 945 were included as trailer bill language in AB 1810 (Committee on Budget, Assembly) which was signed into law eliminating the treatment term limits. The Budget includes $8.4 million General Fund allocation for this purpose.	**06/26/2018** Held in the Assembly Health Committee at the request of the author **05/29/2018** Passed Senate Floor and ordered to the Assembly **01/29/2018** Introduced	Watch LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2275 Arambula	**Medi-Cal Quality Requirements:** Would create new quality requirements for Medi-Cal managed care plans, which would be a significant departure from the state's current quality assurance and performance improvement program. Amended language allows National Committee for Quality Assurance (NCQA) accredited plans, like CalOptima, to submit survey data collected annually as part of the NCQA accreditation. *After bills are passed by the Legislation and are presented to the Governor, he has until September 30, 2018 to sign or veto bills, or he can choose to take no action, in which case a bill would become chaptered without his signature immediately after the September 30 deadline. A chaptered bill becomes effective January 1, 2019 unless it contains an urgency clause or specifies its own effective date.*	**09/12/2018** Vetoed by the Governor **09/06/2018** Sent to the Governor's Desk **08/28/2018** Assembly concurred in Senate amendments **02/13/2018** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2299 Chu	**Materials for Medi-Cal Members:** Requires all Medi-Cal managed care plans' (MCPs) written health education and informational materials to meet a readability and suitability checklist established by DHCS. Informational materials would also be required to go through a "community review" process prior to submission to DHCS. Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. Currently, CalOptima's Health Education and Cultural Linguistic Services departments already review all informational materials released to members in all threshold languages. This bill would add an additional step – the community review – to the current process. This additional step could delay the release of member materials for an additional 45 days. According to analysis conducted by staff, while the intent of the bill appears to benefit members, these added requirements would create unnecessary delays in releasing information to members.	**09/19/2018** Vetoed by the Governor **09/05/2018** Sent to the Governor's Desk **08/27/2018** Assembly concurred in Senate amendments **02/13/2018** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author
AB 2579 Burke	**WIC to Medi-Cal Express Lane:** Would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to Medi-Cal. WIC is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2193 Maienschein	**Maternal Mental Health Program:** Requires health plans to develop a maternal mental health program to address mental health conditions that occur during pregnancy or postpartum period. Upon analysis by staff, CalOptima's Comprehensive Perinatal Services Program (CPSP) appears to comply with the requirements of the bill as these overlap with existing standards and requirements in Medi-Cal managed care contracts.	**09/26/2018** Signed into law by the Governor **09/06/2018** Sent to the Governor's Desk **08/29/18** Assembly concurred in Senate amendments **02/12/2018** Introduced	Watch CalOptima provided feedback to LHPC
AB 315 Wood	**Pharmacy Benefit Management:** Among other provisions, this bill requires health plans that contract with PBMs for management of any or all its prescription drug coverage to require the PBMs to register with the Department of Managed Health Care (DMHC), to give a 30-day cancelation notice to contracted pharmacies before terminating their contract, and to disclose to network pharmacies any material change to a contract provision that would affect the terms of reimbursement, among other requirements. The bill also requires network pharmacies to notify consumers, at point of sale, whether a drugs' retail price or its contract price is lower. The bill's regulatory and transparency requirements on PBMs will have ramifications for health plans, like CalOptima, that assign PBMs a central role in the management of their pharmacy benefits. Specifically, the requirement that PBMs register with DMHC would require CalOptima, in turn, to amend its contract with its PBM to include a written attestation of compliance with the bill's requirements by January 2020 deadline.	**09/29/2018** Signed into law by the Governor **09/06/2018** Sent to the Governor's Desk **08/29/2018** Assembly concurred in Senate amendments **02/21/2017** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to LHPC and CAHP
SB 1125 Atkins	**Access to Mental Health at FQHCs:** Would allow a Federally Qualified Health Center (FQHC) to be reimbursed by the state for a mental health visit that occurs on the same day as a medical face-to-face visit. Currently, a patient must seek mental health treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would give members access to both primary care and on-site mental health care on the same day, while ensuring that clinics are appropriately reimbursed for both services. Currently, approximately 138,000 CalOptima members receive care at FQHCs.	**9/27/2018** Vetoed by the Governor **09/12/2018** Sent to the Governor's Desk **08/31/2018** Senate concurred in Assembly amendments **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 2029 Garcia	**Billable Visits for Service Outside the FQHC's Four Walls:** Among other provisions, this bill would align state and federal regulations to allow FQHCs to bill for services provided to CalOptima members outside the FQHC's four walls. Current federal law allows FQHCs to provide services to patients at temporary shelters, a beneficiary's residence, a location of another provider, or any location approved by the U.S. Health Resources and Services Administration (HRSA). Allowing FQHCs to bill for services outside their four walls would expand access to care for CalOptima members who are homebound, require specialized transportation or reside in temporary shelters.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **02/05/2018** Introduced	Watch CalOptima provided feedback as part of LHPC comment letter to the bill author

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2965 Arambula	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are under 26 years of age, regardless of immigration status.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/16/2018** Introduced	Watch CAHP: Support LHPC: Support
SB 974 Lara	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are 65 years of age or older, regardless of immigration status.	**08/16/2018** Held in Assembly Appropriations Committee Suspense File **05/30/2018** Passed Senate Floor and ordered to the Assembly **02/01/2018** Introduced	Watch LHPC: Support
AB 2718 Friedman	**Transitional Medi-Cal Eligibility for CalWORKs Recipients:** Extends Medi-Cal eligibility from six months to twelve months for families transitioning off the California Work Opportunity and Responsibility to Kids program (CalWORKs). Current state policy allows for a six-month extension of coverage after a family exits the program, and an additional six months if their income remains at or below 185 percent FPL. This bill would allow families to retain access to Medi-Cal coverage for twelve months, regardless of income, by requiring the state to implement the federally allowable twelve-month period option.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch
AB 2203 Gray	**Medi-Cal Provider Rates:** Beginning July 1, 2019, would require DHCS to increase Medi-Cal primary care provider rates to the rate paid for those services under the federal Medicare program.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/12/2018** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2122 Reyes	**Pediatric Blood Lead Testing:** Would require DHCS to notify parents of children enrolled in Medi-Cal of lead testing requirements and inform them when their children have missed the test. Under current law, children are to be tested at 12 months of age and again at 24 months. This bill would require DHCS to report its progress in meeting the lead testing requirements on an annual basis. Medi-Cal managed care plans would be required to notify and educate health care providers that fail to blood test at least eighty percent of enrolled children. According to the bill language, a disproportionate number of children who test positive for lead-poisoning are enrolled in Medi-Cal.	**09/22/2018** Vetoed by the Governor **09/10/2018** Sent to the Governor's Desk **08/30/2018** Assembly concurred in Senate amendments **02/08/2018** Introduced	Watch CalOptima provided feedback to the bill author
AB 2472 Wood	**Medi-Cal Public Option Feasibility Study:** Requires the newly established Council on Health Care Delivery System to prepare a feasibility study to assess the possibility of establishing a public health insurance plan. The plan would permit individuals whose income is greater than 138 percent of the federal poverty level to purchase coverage. Among other requirements, the study would explore the feasibility of allowing Medi-Cal managed care plans to negotiate with Covered California regarding offering products on the California Health Benefit Exchange in counties where only two or fewer plans are available for purchase through the Exchange.	**09/22/2018** Signed into law by the Governor **09/05/2018** Sent to the Governor's Desk **08/27/18** Assembly concurred in Senate amendments **02/14/2018** Introduced	Watch
AB 3175 Rubio	**Child Life Specialist:** Would require that services provided by certified child life specialists be covered under the California Children's Services (CCS) program. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with specialized health care conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, among others. CCS-eligible children living in select counties, including Orange County, will transition from fee-for-service to Medi-Cal managed care as part of the Whole Child Model (WCM), established as part of SB 586 (Chapter 625, Statutes of 2016). In Orange County, the CCS WCM transition is scheduled to take place in January 2019. Certified child life specialists are allied health care professionals that support children and families coping with the stress and uncertainty of life altering healthcare crises.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/16/2018** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 906 Beall	**Medi-Cal Mental Health Services Peer Certification:** Would require DHCS to establish a statewide certification program for peer and family support specialists and to include as a service to be reimbursed under the Medi-Cal program. Among other responsibilities, a peer and family support specialist would provide individualized support services to members with mental health care needs and substance use disorders.	**09/29/2018** Vetoed by the Governor **09/12/2018** Sent to the Governor's Desk **08/31/2018** Senate concurred in Assembly amendments **05/30/2018** Passed Senate Floor and ordered to the Assembly **01/17/2018** Introduced	Watch
SB 399 Portantino	**Autism Spectrum Disorder Treatment:** Would make changes to current law related to the treatment of Autism Spectrum Disorder, such that managed care plans would be required to cover certain treatment protocols that are not currently covered, such as the Developmental Individual-difference Relationship (DIR) model and "Floortime." These therapies are intended to be spontaneous play sessions between a child with autism and an adult. Also, this bill would reduce the required educational levels of autism service paraprofessionals.	**09/29/2018** Vetoed by the Governor **09/05/2018** Sent to the Governor's Desk **08/28/2018** Senate concurred in Assembly amendments **01/29/2018** Passed Senate Floor and ordered to the Assembly **02/15/2017** Introduced	Watch CAHP: Oppose LHPC: Oppose
AB 2565 Chiu	**Covered California Premium Assistance:** Would require Covered California to offer enhanced premium assistance to individuals between 200 percent and 400 percent FPL who enroll in health care coverage through the Exchange. The enhanced premium assistance would be in addition to the current federal subsidies. According to the bill author, the cost to the state would be $300 million, and would increase financial assistance to approximately 550,000 people enrolled in Covered California. While this bill does not impact Medi-Cal directly, it is of interest to CalOptima because individuals often "churn" between Medi-Cal and the individual market.	**08/16/2018** Held in Senate Appropriations Committee Suspense File **05/30/2018** Passed Assembly Floor and ordered to the Senate **02/15/2018** Introduced	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 171 Hernandez	**Medicaid Managed Care Final Rule ("Mega Reg"):** Implements certain provisions of the Mega Reg by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill changes the way public hospitals receive supplemental payments and creates a new, across-the-board Medical Loss Ratio (MLR) standard for Medi-Cal managed care plans. DHCS received federal approval for the new public hospitals directed payment structure, comprised of the Enhanced Payment Program (EPP) and the Quality Incentive Program (QIP), in April 2018.	**10/13/2017** Signed into law by the Governor	Watch
SB 608 Hernandez	**Hospital Quality Assurance Fee (QAF):** Would modify the QAF to bring it into compliance with CMS Medicaid Managed Care Final Rule requirements. The current language of the bill only reflects a portion of the California Hospital Association's proposal to reform the QAF. DHCS received federal approval for the new Private Hospital Directed Payment (PHDP) structure in March 2018. The new structure begins a 10-year phase out of the current QAF structure and phase in of the PHDP.	**09/01/2017** Held under submission	Watch

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

Last Updated: October 24, 2018

2018 Federal Legislative Dates

January 3	116th Congress convenes 1st session
March 26–April 9	Spring recess
July 27–September 3	Summer recess
November 6	General Election

2018 State Legislative Dates

January 3	Legislature reconvenes
February 16	Last day for legislation to be introduced
April 27	Last day for policy committees to hear and report bills to fiscal committees
May 11	Last day for policy committees to hear and report non-fiscal bills to the floor
May 25	Last day for fiscal committees to report fiscal bills to the floor
May 29–June1	Floor session only
June 1	Last day to pass bills out of their house of origin
June 5	Statewide Primary Election
June 15	Budget bill must be passed by midnight
June 28	Last day for a legislative measure to qualify for the Nov. 6 General Election ballot
July 6–August 5	Summer recess
August 7	Special Election for CA Senate District 32
August 17	Last day for fiscal committees to report bills to the floor
August 20 – 31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 6	General Election
November 30	Adjournment *Sine Die* at midnight
December 3	Convening of the 2019-20 session

Sources: 2018 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Whole-Child Model (WCM) Update

Board of Directors Meeting
December 6, 2018

Candice Gomez, Executive Director, Program Implementation

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WCM Update

- Department of Health Care Services (DHCS) notified CalOptima about delayed implementation
  - CalOptima to implement in Phase 3, beginning no sooner than July 1, 2019
  - Basis for the delay
    - Size of California Children's Services (CCS) population in Orange County
    - Complexity of CalOptima's delegated health network model
  - Goals of the delay
    - Ensure care is integrated and easier to navigate
    - Verify that a robust number of CCS-paneled providers is prepared to deliver quality care
  - Until WCM implementation, children enrolled in CalOptima and CCS will continue to receive CCS services through the county CCS program

Stakeholder Notification

- Members
  - Mailed notices and call campaign
- Health networks
  - Conference call, Health Network Forum and written notice
- Providers
  - Blast fax, provider newsletter and targeted outreach
- Community-based organizations
  - Community Connections newsletter and written notice
- General public
  - Website update

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DHCS Regulatory Changes

- Updated WCM network adequacy requirements
  - Released November 21, 2018
- All Plan Letter (APL) 18-011: California Children's Services Program Whole-Child Model
  - Updated APL pending
- Neonatal Intensive Care Unit (NICU) carve-in
  - Verbally announced but not yet documented in APL or DHCS contract

Network Adequacy Compliance

- DHCS released network adequacy assessment results on November 21, 2018
  - Assessment evaluates individual health networks based on adequacy of contracted specialists by type (e.g., cardiology, infectious disease, neurology, etc.)
  - Health networks must meet adequacy requirements by January 2, 2019
    - CalOptima may attest to DHCS that a health network will meet adequacy requirements if deficiencies can be corrected by March 1, 2019
  - Health networks that do not meet adequacy requirements will be excluded from the July 2019 WCM launch
    - Can participate at later date once requirements are met

Member Impact

- Networks not participating in WCM will create three situations for members
  - Current CCS-eligible members assigned to a health network
    - Will require one-time transition process
  - New members to CalOptima who are CCS-eligible
    - Changes to new member assignment policies
  - Health network members who become CCS-eligible
    - Will require changes to member assignment policies and a transition process

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Next Steps

- Work with health networks to address deficiencies
- Continue stakeholder engagement
  - Board advisory committees
  - Associations
  - Community-based organizations
- Review and update policies
  - Changes, if needed, will address network adequacy requirements or other programmatic changes
  - Provisions related to WCM will not be effective until go-live
- Gain Board approval for health network contract amendments
- Return to Board in February and March, as needed

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Continued to February 7, 2019 Board Meeting

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Overview of Marketing and Educational Efforts

Board of Directors Meeting

December 6, 2018

Bridget Kelly

Director, Communications

Background

- Marketing is closely regulated
  - Regulations prohibit promotion of enrollment in Medi-Cal
  - Allows promotion of competitive programs
- Primary focus of marketing efforts
  - Promote enrollment in competitive programs
    - Healthy Families (1998)
    - OneCare (2005)
    - PACE (2013)
    - OneCare Connect (2015)
- Primary focus of educational efforts
  - Improve HEDIS quality scores
  - Raise awareness about preventive health and wellness topics

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Considerations

- Identify target audience based on program
- Evaluate key considerations, including geographic reach and best method of outreach within approved budget
- Develop campaigns in a collaborative manner with input from internal leadership and staff as well as external stakeholders

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Campaign Development

- Craft messages that meet regulator requirements and identified goals for competitive programs
- Craft messages that meet identified goals for educational efforts
  - Educate members to improve HEDIS performance
  - Respond to Member Health Needs Assessment and/or Consumer Assessment of Healthcare Providers and Systems (CAHPS) findings
- Develop a selection of marketing and educational concepts using internal copywriting and graphic teams

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Campaign Feedback and Awareness

- Gather feedback on concepts from member-facing departments
  - Community Relations
  - Cultural and Linguistic Services
  - Customer Service
  - Advisory Committees
  - Health Education
  - Provider Relations
  - Quality Analytics
- Conduct member and community focus groups
  - Refine messages and ensure they resonate with the intended audience
  - Convey messages in a culturally relevant manner
- Communicate the marketing and educational schedule to the Board

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Marketing and Educational Placement

- CalOptima uses a multifaceted approach to reach our target audiences, marketing in multiple vehicles
  1. Print ads
     - Newspapers (OC Register, Senior Reporter, Hoy Fin de Semana, Viet Bao, Vien Dong and Nguoi Viet)
     - Magazines (El Clasificado)
     - Resource directories (Answers Guide and California Senior Guide)
  2. Outdoor ads
     - Digital and traditional billboards
     - OCTA buses
     - Transit shelters
     - Store-front promotion (e.g. markets, laundromats, beauty and nail salons)

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Marketing and Educational Placement (cont.)

3. Radio ads in non-English threshold languages
   - Recorded scripts
   - On-air mentions
   - Interviews with on-air hosts
   - On-location promotional events
4. Digital ads
   - Geotargeted ads on mobile devices in areas with high member concentration
   - Targeted display ads through vendor's shared network
   - Retargeted ads based on user search profiles, e.g., ads for prenatal care after the user searched for pregnancy information
   - Social media, such as Facebook

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Decision-Making Process

- Review data and information supplied by vendors
- Match potential marketing vehicles to the target audience
  - Geographic distribution
  - Member media preference
- Maximize impact using complementary marketing placement

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Decision-Making Process (cont.)

- Use procurement policy (GA.5002) to purchase identified marketing and educational opportunities
  - Annual budget authorized by Board of Directors
  - Expenses under $10,000
    - No bid required
  - Expense between $10,000 and $50,000
    - Informal bid
  - Expense over $50,000
    - Formal bid (RFP process)

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FY15–FY19 Budgets

Program	FY15	FY16	FY17	FY18	FY19
OneCare Connect (Marketing)	$115,800	$484,182[1]	$333,803[2]	$267,000	$200,000
PACE (Marketing)	$0[3]	$0[3]	$0[3]	$192,996	$250,000
Medi-Cal (Educational)	$293,060	$354,000	$146,143	$177,000	$170,000
Total	$408,860	$838,182	$479,946	$636,996	$620,000

[1] The OneCare Connect program began in July 2015. Consequently, the FY16 budget was higher than usual to account for planning and program launch activities.

[2] The direct mail expenses for OneCare Connect began in FY17 and were included in the advertising GL (025). Starting in FY18, those expenses were moved to the member communications GL (062).

[3] Prior to FY18, the PACE marketing budget was included in the Medi-Cal budget.

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Current Educational Campaign — Quality Care

- Highlight CalOptima as California's top-rated Medi-Cal plan
- Encourage members to obtain services that contribute to higher HEDIS quality scores in five key areas
  - Prenatal care
  - Childhood immunizations
  - Behavioral health
  - Breast cancer screenings
  - Well-care visits
- Increase general community awareness about the importance of preventive health and wellness

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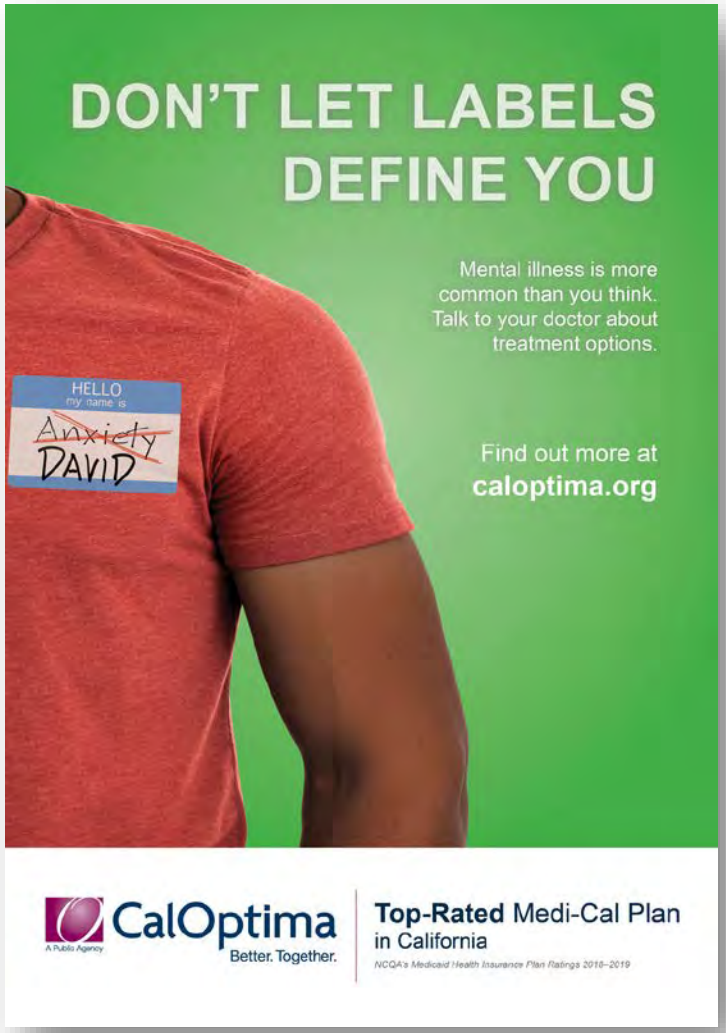
Current Educational Campaign — Quality Care



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Current Marketing Campaign — OneCare Connect

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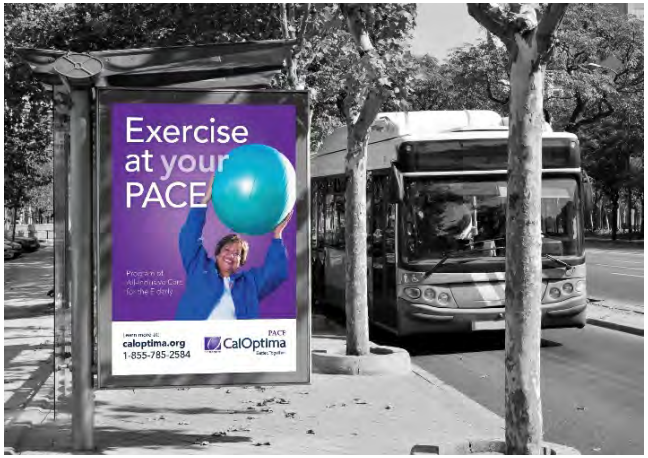
Current Marketing Campaign — PACE



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Marketing and Educational Vehicles

- CalOptima leverages established communication vehicles to extend campaign impact
  - Collateral materials
  - Community Connections
  - Provider Press
  - Provider Update
  - Website
  - Social Media

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Next Steps

- Obtain feedback from Board of Directors
  - Marketing and educational efforts process
  - If necessary, establish updated general marketing policy and obtain Board approval

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MEMORANDUM

DATE:	November 16, 2018
TO:	Liz Le, Director, Network Management, Health Network Relations
FROM:	TC Roady, Director, Regulatory Affairs & Compliance (Medi-Cal)
SUBJECT:	DMHC Closed Pending Regulations Re: General Licensure Requirements
COPY:	Ladan Khamseh, Chief Operating Officer Michelle Laughlin, Executive Director, Provider Network Operations

During yesterday's Health Network Forum meeting, I provided a verbal summary of the Department of Managed Health Care's (DMHC) proposed Knox Keene Act (the Act) regulation addressing Health Care Service plan licensure. Following my comments, a representative of one of CalOptima's Health Networks requested that additional written comments be shared on the subject.

This memo discusses the proposed regulation, Section 1300.49 of Title 28 of the California Code of Regulations (referred to as the "Regulation" or "Section 1300.49"), which was drafted to establish new requirements for health care service plan licensure, including "restricted health care service plans." Parties who assume "global risk" as defined in the Regulation must be licensed by the DMHC.

As part of the rulemaking process, the Regulation was submitted on August 24, 2018, to the Office of Administrative Law (OAL) for approval following the conclusion of three public comment periods. However, on October 9, 2018, the OAL disapproved the Regulation based on its failure to comply with the "clarity standard" under the California Administrative Law Act and the DMHC's failure to comply with certain technical requirements. Specifically, the Regulation provides that the DMHC Director may grant an exemption from the licensure requirement upon a finding that the action is in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under the Act. The OAL determined that the standard for exemption set by the proposed Regulation was unclear (1) as to what would be in the public interest and not detrimental and (2) as to what criteria the DMHC would use in determining whether to grant exemption requests. The OAL also determined that the public would have difficulty utilizing the exemption due to an absence of application procedures

These points were raised during the public comment periods (including by the Local Health Plans of California (LHPC), the California Association of Health Plans (CAHP), Stanford Health Care, the California Association of Physician Groups (CAPG) and others); however, the DMHC declined to provide additional clarification and essentially indicated it would make exemption determinations on a case-by-case basis.

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Based on the OAL's disapproval of the proposed Regulation, the DMHC has 120 days from the October 15, 2018 OAL decision date to resubmit the Regulation for further OAL review. Proposed changes to address the clarity deficiency must be made available for public comment for at least 15 days prior to the resubmission.

The proposed Regulation does not impact CalOptima directly because CalOptima is either Knox Keene licensed or exempt from DMHC's licensure requirements for its various health care programs. However, the Regulation may impact some of CalOptima's health networks based on our risk pool arrangements. CalOptima contracts with health networks under three capitated models: (1) HMO or full risk (both institutional and professional); (2) Physician-Hospital Consortium (PHC), where CalOptima contracts with a physician group for professional services and separately contracts with the medical group's hospital partner for institutional services; and (3) Shared Risk (SRG) where CalOptima contracts with a physician group for professional services, but separately contracts for hospital services on a fee-for-service basis.

CalOptima requires its HMO health networks to be licensed by the DMHC. CalOptima's PHC and SRG health networks generally receive capitation sufficient to cover the services they are contracted to provide; however, they also participate in risk pools designed to reward them for effective utilization management. Historically, the DMHC's concerns with risk pools focused on how risk pool deficits were handled, including how any such deficits are recovered from physician groups (*e.g.,* offsets to capitation, repayment upon termination, etc.) The PHC risk pool parameters and SRG risk pool structure were designed to avoid certain longstanding concerns that have been raised by the DMHC and its predecessor, the Department of Corporations. For the PHC risk pools, this includes a limitation on Physician Group down-side risk, and for SRG risk pools, it includes forgiveness of risk pool deficits allocated to the Physician Groups.

CalOptima will be in a better position to evaluate what, if any, steps are necessary to comply with the Regulation once the formal rulemaking process is concluded. At that point, we hope to have guidance from the DMHC clarifying whether CalOptima's PHC and SRG health network risk pool models are excluded based on CalOptima's exemptions or, if not, whether they may be granted an exemption by DMHC based on the current health network models. CalOptima's Government Affairs Department will coordinate comments on the revised/clarified Regulation with the LHPC and CAHP trade associations. Notwithstanding CalOptima's actions in response to the final Regulation, health networks need to separately review the impact of the Regulation's licensing requirements on their arrangements with other health care service plans, if any.

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Financial Summary

October 2018

Board of Directors Meeting

December 6, 2018

Greg Hamblin

Chief Financial Officer

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FY 2018-19: Consolidated Enrollment

- October 2018 MTD:
  - Overall enrollment was 772,846 member months
    - Actual lower than budget 11,502 or 1.5%
      - Medi-Cal: unfavorable variance of 11,367 members
        - Temporary Assistance for Needy Families (TANF) unfavorable variance of 6,087 members
        - Medi-Cal Expansion (MCE) unfavorable variance of 4,579 members
        - Seniors and Persons with Disabilities (SPD) unfavorable variance of 648 members
        - Long-Term Care (LTC) unfavorable variance of 53 members
      - OneCare Connect: unfavorable variance of 214 members
    - 1,594 decrease from prior month
      - Medi-Cal: decrease of 1,610 from September
      - OneCare Connect: decrease of 16 from September
      - OneCare: increase of 29 from September
      - PACE: increase of 3 from September

FY 2018-19: Consolidated Enrollment (cont.)

- October 2018 YTD:
  - Overall enrollment was 3,101,661 member months
    - Actual lower than budget 37,362 or 1.2%
      - Medi-Cal: unfavorable variance of 36,915 members or 1.2%
        - TANF unfavorable variance of 19,369 members
        - MCE unfavorable variance of 15,682 members
        - SPD unfavorable variance of 1,573 members
        - LTC unfavorable variance of 291 members
      - OneCare Connect: unfavorable variance of 717 members or 1.2%
      - OneCare: favorable variance of 257 or 4.9%
      - PACE: favorable variance of 13 members or 1.2%

FY 2018-19: Consolidated Revenues

- October 2018 MTD:
  - ➢ Actual lower than budget $6.0 million or 2.2%
    - Medi-Cal: unfavorable to budget $2.5 million or 1.0%
      - Unfavorable volume variance of $3.7 million
      - Favorable price variance of $1.2 million
    - OneCare Connect: unfavorable to budget $3.4 million or 13.5%
      - Unfavorable volume variance of $0.4 million
      - Unfavorable price variance of $3.0 million due to Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2017 Part D true-up
    - OneCare: unfavorable to budget $188.3 thousand or 11.7%
      - Favorable volume variance of $97.2 thousand
      - Unfavorable price variance of $285.5 thousand
    - PACE: favorable to budget $37.1 thousand or 1.8%
      - Unfavorable volume variance of $7.2 thousand
      - Favorable price variance of $44.3 thousand

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FY 2018-19: Consolidated Revenues (cont.)

- October 2018 YTD:
  - Actual lower than budget $6.9 million or 0.6%
    - Medi-Cal: unfavorable to budget $6.3 million or 0.6%
      - Unfavorable volume variance of $11.9 million
      - Favorable price variance of $5.6 million due to:
        - $4.7 million of FY18 LTC revenue from non-LTC aid codes
        - $4.0 million of FY18 Coordinated Care Initiative (CCI) revenue
        - $1.7 million of FY18 Hepatitis C revenue
        - ($5.6) million of FY19 non-LTC revenue from non-LTC aid codes

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FY 2018-19: Consolidated Revenues (cont.)

- October 2018 YTD:
  - OneCare Connect: favorable to budget $0.4 million or 0.4%
    - Unfavorable volume variance of $1.2 million due to enrollment adjustment
    - Favorable price variance of $1.6 million related to 2016 Quality Withhold payback
  - OneCare: Unfavorable to budget $1.2 million or 19.4%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $1.5 million due to CY 2015 risk adjustment
  - PACE: favorable to budget $0.3 million or 3.2%
    - Favorable volume variance of $0.1 million
    - Favorable price variance of $0.2 million

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FY 2018-19: Consolidated Medical Expenses

- October 2018 MTD:
  - ➢ Actual lower than budget $5.6 million or 2.1%
    - ▪ Medi-Cal: favorable variance of $5.8 million
      - Favorable volume variance of $3.5 million
      - Favorable price variance of $2.3 million
        - ➢ Professional Claim expenses favorable variance of $5.9 million due to Child Health and Disability Prevention Program (CHDP) and Proposition 56 expenses recorded in Provider Capitation, offset by Incurred But Not Reported (IBNR)
        - ➢ Managed Long Term Services and Supports (MLTSS) expenses favorable variance of $2.1 million due to IBNR
        - ➢ Facilities expenses unfavorable variance of $3.5 million due to higher crossover and outpatient claims
        - ➢ Provider Capitation expenses unfavorable variance of $3.7 million due to Proposition 56 and CHDP expenses that were budgeted in Professional Claims
        - ➢ Prescription Drug expenses favorable variance of $1.0 million

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FY 2018-19: Consolidated Medical Expenses (cont.)

- October 2018 MTD:
  - OneCare Connect: favorable variance of $42.7 thousand or 0.2%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $0.3 million
  - OneCare: unfavorable variance of $196.2 thousand
  - PACE: unfavorable variance of $20.5 thousand

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FY 2018-19: Consolidated Medical Expenses (cont.)

- October 2018 YTD:
  - Actual lower than budget $12.7 million or 1.2%
    - Medi-Cal: favorable variance of $11.6 million
      - Favorable volume variance of $11.3 million
      - Favorable price variance of $0.3 million
        - Professional Claim expenses favorable variance of $20.2 million
        - Facilities expenses unfavorable variance of $15.0 million
        - Provider Capitation expenses unfavorable variance of $14.5 million
        - Prescription Drug expenses favorable variance of $5.7 million
    - OneCare Connect: favorable variance of $0.6 million
      - Favorable volume variance of $1.2 million
      - Unfavorable price variance of $0.6 million

- Medical Loss Ratio (MLR):
  - October 2018 MTD: Actual: 96.2% Budget: 96.1%
  - October 2018 YTD: Actual: 94.8% Budget: 95.3%

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FY 2018-19: Consolidated Administrative Expenses

- October 2018 MTD:
  - Actual lower than budget $2.8 million or 21.1%
    - Salaries, wages and benefits: favorable variance of $1.5 million
    - Other categories: favorable variance of $1.3 million

- October 2018 YTD:
  - Actual lower than budget $10.7 million or 20.9%
    - Salaries, wages & benefits: favorable variance of $5.6 million
    - Purchased Services: favorable variance of $1.6 million
    - Other categories: favorable variance of $3.5 million

- Administrative Loss Ratio (ALR):
  - October 2018 MTD: Actual: 3.8% Budget: 4.8%
  - October 2018 YTD: Actual: 3.7% Budget: 4.6%

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FY 2018-19: Change in Net Assets

- October 2018 MTD:
  - $2.0 million surplus
  - $4.0 million favorable to budget
    - Lower than budgeted revenue of $6.0 million
    - Lower than budgeted medical expenses of $5.6 million
    - Lower than budgeted administrative expenses of $2.8 million
    - Higher than budgeted investment and other income of $1.6 million

- October 2018 YTD:
  - $25.6 million surplus
  - $23.4 million favorable to budget
    - Lower than budgeted revenue of $6.9 million
    - Lower than budgeted medical expenses of $12.7 million
    - Lower than budgeted administrative expenses of $10.7 million
    - Higher than budgeted investment and other income of $7.0 million

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Enrollment Summary: October 2018

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
64,015	64,443	(428)	(0.7%)	Aged	255,311	256,428	(1,117)	(0.4%)
596	620	(24)	(3.9%)	BCCTP	2,458	2,480	(22)	(0.9%)
46,935	47,131	(196)	(0.4%)	Disabled	188,036	188,470	(434)	(0.2%)
310,181	315,152	(4,971)	(1.6%)	TANF Child	1,248,996	1,263,723	(14,727)	(1.2%)
93,667	94,783	(1,116)	(1.2%)	TANF Adult	376,566	381,208	(4,642)	(1.2%)
3,429	3,482	(53)	(1.5%)	LTC	13,571	13,862	(291)	(2.1%)
237,665	242,244	(4,579)	(1.9%)	MCE	951,154	966,836	(15,682)	(1.6%)
756,488	**767,855**	**(11,367)**	**(1.5%)**	**Medi-Cal**	**3,036,092**	**3,073,007**	**(36,915)**	**(1.2%)**
14,665	**14,879**	**(214)**	**(1.4%)**	**OneCare Connect**	**58,882**	**59,599**	**(717)**	**(1.2%)**
289	**290**	**(1)**	**(0.3%)**	**PACE**	**1,134**	**1,121**	**13**	**1.2%**
1,404	**1,324**	**80**	**6.0%**	**OneCare**	**5,553**	**5,296**	**257**	**4.9%**
772,846	**784,348**	**(11,502)**	**(1.5%)**	**CalOptima Total**	**3,101,661**	**3,139,023**	**(37,362)**	**(1.2%)**

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Financial Highlights: October 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
772,846	784,348	(11,502)	(1.5%)	Member Months	3,101,661	3,139,023	(37,362)	(1.2%)
271,559,256	277,563,668	(6,004,413)	(2.2%)	Revenues	1,098,337,086	1,105,278,324	(6,941,237)	(0.6%)
261,188,770	266,806,639	5,617,869	2.1%	Medical Expenses	1,041,082,075	1,053,775,200	12,693,126	1.2%
10,414,766	13,198,471	2,783,705	21.1%	Administrative Expenses	40,325,512	50,981,219	10,655,707	20.9%
(44,280)	**(2,441,442)**	**2,397,161**	**98.2%**	**Operating Margin**	**16,929,500**	**521,905**	**16,407,595**	**3143.8%**
2,060,395	416,667	1,643,729	394.5%	Non Operating Income (Loss)	8,681,339	1,666,667	7,014,672	420.9%
2,016,115	**(2,024,775)**	**4,040,890**	**199.6%**	**Change in Net Assets**	**25,610,839**	**2,188,572**	**23,422,267**	**1070.2%**
96.2%	96.1%	(0.1%)		Medical Loss Ratio	94.8%	95.3%	0.6%	
3.8%	4.8%	0.9%		Administrative Loss Ratio	3.7%	4.6%	0.9%	
(0.0%)	(0.9%)	0.9%		Operating Margin Ratio	1.5%	0.0%	1.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: October 2018 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
5.1	(0.9)	6.0	Medi-Cal	19.8	5.0	14.8
(4.8)	(1.4)	(3.4)	OCC	(2.4)	(4.2)	1.8
(0.4)	(0.1)	(0.3)	OneCare	(1.3)	(0.3)	(1.0)
0.0	(0.0)	0.1	PACE	0.8	0.0	0.8
(0.0)	**(2.4)**	**2.4**	**Operating**	**16.9**	**0.5**	**16.4**
2.1	0.4	1.6	Inv./Rental Inc, MCO tax	8.7	1.7	7.0
2.1	**0.4**	**1.6**	**Non-Operating**	**8.7**	**1.7**	**7.0**
2.0	**(2.0)**	**4.0**	**TOTAL**	**25.6**	**2.2**	**23.4**

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Consolidated Revenue & Expense: October 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	518,823	237,665	756,488	14,665	1,404	289	772,846
REVENUES							
Capitation Revenue	$ 136,091,545	$ 110,454,091	$ 246,545,636	$ 21,457,919	$ 1,419,685	$ 2,136,015	$ 271,559,256
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	136,091,545	110,454,091	246,545,636	21,457,919	1,419,685	2,136,015	271,559,256
MEDICAL EXPENSES							
Provider Capitation	35,418,123	50,629,882	86,048,005	11,226,570	401,588		97,676,163
Facilities	23,187,964	23,670,684	46,858,648	3,494,523	695,246	604,273	51,652,690
Ancillary	-	-	-	767,461	69,776	-	837,237
Professional Claims	16,925,328	6,136,746	23,062,074	-	-	367,045	23,429,118
Prescription Drugs	17,615,095	20,268,875	37,883,970	5,465,037	454,076	181,487	43,984,569
MLTSS	31,579,548	2,703,703	34,283,252	1,620,102	67,956	(1,808)	35,969,501
Medical Management	1,762,028	1,126,399	2,888,426	1,148,988	54,498	667,870	4,759,782
Quality Incentives	774,166	412,842	1,187,008	281,000		2,890	1,470,898
Reinsurance & Other	471,125	561,480	1,032,604	231,511	2,416	142,280	1,408,811
Total Medical Expenses	127,733,376	105,510,610	233,243,986	24,235,190	1,745,557	1,964,037	261,188,770
Medical Loss Ratio	**93.9%**	**95.5%**	**94.6%**	**112.9%**	**123.0%**	**91.9%**	**96.2%**
GROSS MARGIN	**8,358,169**	**4,943,481**	**13,301,650**	**(2,777,271)**	**(325,872)**	**171,979**	**10,370,485**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,225,554	771,277	32,764	99,548	7,129,143
Professional fees			174,593	36,113	14,666	(259)	225,114
Purchased services			589,201	170,707	1,706	19,489	781,102
Printing & Postage			277,796	155,415	26,083	4	459,298
Depreciation & Amortization			366,624			2,072	368,695
Other expenses			1,106,600	46,538		5,187	1,158,325
Indirect cost allocation & Occupancy			(521,663)	798,228	11,794	4,731	293,089
Total Administrative Expenses			8,218,705	1,978,277	87,013	130,771	10,414,766
Admin Loss Ratio			**3.3%**	**9.2%**	**6.1%**	**6.1%**	**3.8%**
INCOME (LOSS) FROM OPERATIONS			5,082,945	(4,755,548)	(412,884)	41,207	(44,280)
INVESTMENT INCOME							2,063,843
TOTAL GRANT INCOME			(3,460)				(3,460)
OTHER INCOME			12				12
CHANGE IN NET ASSETS			**$ 5,079,496**	**$ (4,755,548)**	**$ (412,884)**	**$ 41,207**	**$ 2,016,115**
BUDGETED CHANGE IN NET ASSETS			(936,963)	(1,394,773)	(75,250)	(34,456)	(2,024,775)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 6,016,460	$ (3,360,775)	$ (337,635)	$ 75,663	$ 4,040,890

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Consolidated Revenue & Expense: October 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,084,938	951,154	3,036,092	58,882	5,553	1,134	3,101,661
REVENUES							
Capitation Revenue	$ 541,401,572	$ 443,446,402	$ 984,847,974	$ 99,980,885	$ 5,128,686	$ 8,379,541	$ 1,098,337,086
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	541,401,572	443,446,402	984,847,974	99,980,885	5,128,686	8,379,541	1,098,337,086
MEDICAL EXPENSES							
Provider Capitation	143,031,220	200,904,160	343,935,379	46,689,127	1,235,988		391,860,494
Facilities	94,219,636	93,418,826	187,638,461	12,715,639	2,249,413	1,742,422	204,345,935
Ancillary	-	-	-	2,358,108	134,180	-	2,492,289
Professional Claims	65,406,859	25,797,795	91,204,654	-	-	1,640,000	92,844,654
Prescription Drugs	69,386,432	78,965,277	148,351,710	21,709,616	1,759,718	616,270	172,437,313
MLTSS	129,853,861	11,415,297	141,269,158	5,746,459	382,863	(843)	147,397,637
Medical Management	7,863,982	3,957,989	11,821,970	4,382,288	220,949	2,390,406	18,815,614
Quality Incentives	3,090,272	1,630,697	4,720,968	1,122,480		11,340	5,854,788
Reinsurance & Other	2,096,792	1,328,466	3,425,258	917,926	20,278	669,889	5,033,352
Total Medical Expenses	514,949,052	417,418,506	932,367,558	95,641,643	6,003,390	7,069,483	1,041,082,075
Medical Loss Ratio	**95.1%**	**94.1%**	**94.7%**	**95.7%**	**117.1%**	**84.4%**	**94.8%**
GROSS MARGIN	**26,452,520**	**26,027,896**	**52,480,416**	**4,339,242**	**(874,704)**	**1,310,059**	**57,255,012**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			23,472,993	3,036,889	120,676	374,449	27,005,008
Professional fees			680,879	103,003	58,667	77	842,625
Purchased services			2,504,511	722,515	52,033	43,704	3,322,763
Printing & Postage			1,177,872	279,916	31,701	21,082	1,510,570
Depreciation & Amortization			1,564,414			8,294	1,572,708
Other expenses			4,475,742	172,658	60	4,460	4,652,920
Indirect cost allocation & Occupancy			(1,182,313)	2,470,410	116,689	14,133	1,418,918
Total Administrative Expenses			32,694,097	6,785,391	379,825	466,199	40,325,512
Admin Loss Ratio			**3.3%**	**6.8%**	**7.4%**	**5.6%**	**3.7%**
INCOME (LOSS) FROM OPERATIONS			19,786,318	(2,446,149)	(1,254,529)	843,860	16,929,500
INVESTMENT INCOME							8,684,208
TOTAL GRANT INCOME			(3,460)				(3,460)
OTHER INCOME			592				592
CHANGE IN NET ASSETS			**$ 19,783,450**	**$ (2,446,149)**	**$ (1,254,529)**	**$ 843,860**	**$ 25,610,839**
BUDGETED CHANGE IN NET ASSETS			4,994,353	(4,229,547)	(273,721)	30,820	2,188,572
VARIANCE TO BUDGET - FAV (UNFAV)			$ 14,789,096	$ 1,783,398	$ (980,808)	$ 813,040	$ 23,422,267

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Balance Sheet:
As of October 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$486,792,772	Accounts Payable	$13,692,368
Investments	459,590,795	Medical Claims liability	785,374,925
Capitation receivable	284,939,880	Accrued Payroll Liabilities	12,986,908
Receivables - Other	23,150,656	Deferred Revenue	86,238,097
Prepaid expenses	5,101,655	Deferred Lease Obligations	95,382
		Capitation and Withholds	122,420,262
Total Current Assets	**1,259,575,759**	**Total Current Liabilities**	**1,020,807,942**
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	8,506,283		
505 City Parkway West	49,743,943		
	92,579,074		
Less: accumulated depreciation	(43,305,932)		
Capital assets, net	49,273,142	Other (than pensions) post employment benefits liability	25,058,410
Other Assets		Net Pension Liabilities	24,772,635
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	9,188,384	**TOTAL LIABILITIES**	**1,070,738,987**
Long-term Investments	531,840,438		
Total Board-designated Assets	541,028,822	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	541,328,822		
TOTAL ASSETS	**1,850,177,723**	TNE	83,204,015
		Funds in Excess of TNE	704,038,391
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	787,242,406
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,861,310,773**	**TOTAL LIABILITIES & FUND BALANCES**	**1,861,310,773**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of October 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	148,122,642				
	Tier 1 - Logan Circle	147,939,189				
	Tier 1 - Wells Capital	147,420,805				
Board-designated Reserve		443,482,636	312,678,371	482,342,251	130,804,265	(38,859,615)
TNE Requirement	Tier 2 - Logan Circle	97,546,186	83,204,015	83,204,015	14,342,171	14,342,171
	Consolidated:	**541,028,823**	**395,882,386**	**565,546,266**	**145,146,436**	**(24,517,443)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

October 2018

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CalOptima - Consolidated
Financial Highlights
For the Four Months Ended October 31, 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
772,846	784,348	(11,502)	(1.5%)	Member Months	3,101,661	3,139,023	(37,362)	(1.2%)
271,559,256	277,563,668	(6,004,413)	(2.2%)	Revenues	1,098,337,086	1,105,278,324	(6,941,237)	(0.6%)
261,188,770	266,806,639	5,617,869	2.1%	Medical Expenses	1,041,082,075	1,053,775,200	12,693,126	1.2%
10,414,766	13,198,471	2,783,705	21.1%	Administrative Expenses	40,325,512	50,981,219	10,655,707	20.9%
(44,280)	**(2,441,442)**	**2,397,161**	**98.2%**	**Operating Margin**	**16,929,500**	**521,905**	**16,407,595**	**3143.8%**
2,060,395	416,667	1,643,729	394.5%	Non Operating Income (Loss)	8,681,339	1,666,667	7,014,672	420.9%
2,016,115	**(2,024,775)**	**4,040,890**	**199.6%**	**Change in Net Assets**	**25,610,839**	**2,188,572**	**23,422,267**	**1070.2%**
96.2%	96.1%	(0.1%)		Medical Loss Ratio	94.8%	95.3%	0.6%	
3.8%	4.8%	0.9%		Administrative Loss Ratio	3.7%	4.6%	0.9%	
(0.0%)	(0.9%)	0.9%		Operating Margin Ratio	1.5%	0.0%	1.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima - Consolidated
Financial Dashboard
For the Four Months Ended October 31, 2018

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	756,488	767,855	(11,367)	(1 5%)
OneCare Connect	14,665	14,879	(214)	(1 4%)
OneCare	1,404	1,324	80	6 0%
PACE	289	290	(1)	(0 3%)
Total	772,846	784,348	(11,502)	(1 5%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 5,079	$ (937)	$ 6,016	642 0%
OneCare Connect	(4,756)	(1,395)	(3,361)	(240 9%)
OneCare	(413)	(75)	(338)	(450 7%)
PACE	41	(34)	75	220 6%
505 Bldg	-	-	-	0 0%
Investment Income & Other	2,064	417	1,647	395 0%
Total	$ 2,015	$ (2,024)	$ 4,039	199 6%

MLR

	Actual	Budget	% Point Var
Medi-Cal	94 6%	96 0%	1 4
OneCare Connect	112 9%	97 8%	(15 1)
OneCare	123 0%	96 4%	(26 6)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,219	$ 10,940	$ 2,721	24 9%
OneCare Connect	1,978	1,935	(44)	(2 3%)
OneCare	87	134	47	35 0%
PACE	131	190	59	31 1%
Total	$ 10,415	$ 13,198	$ 2,784	21 1%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	943	1,064	121
OneCare Connect	218	234	16
OneCare	5	6	1
PACE	61	79	18
Total	1,227	1,383	156

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	802	721	81
OneCare Connect	67	64	4
OneCare	284	221	63
PACE	5	4	1
Total	1,158	1,009	148

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,036,092	3,073,007	(36,915)	(1 2%)
OneCare Connect	58,882	59,599	(717)	(1 2%)
OneCare	5,553	5,296	257	4 9%
PACE	1,134	1,121	13	1 2%
Total	3,101,661	3,139,023	(37,362)	(1 2%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 19,783	$ 4,994	$ 14,789	296 1%
OneCare Connect	(2,446)	(4,230)	1,784	42 2%
OneCare	(1,255)	(274)	(981)	(358 0%)
PACE	844	31	813	2622 6%
505 Bldg	-	-	-	0 0%
Investment Income & Other	8,685	1,667	7,018	421 0%
Total	$ 25,611	$ 2,188	$ 23,423	1070 5%

MLR

	Actual	Budget	% Point Var
Medi-Cal	94 7%	95 2%	0 6
OneCare Connect	95 7%	96 6%	1 0
OneCare	117 1%	96 0%	(21 1)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 32,694	$ 42,186	$ 9,492	22 5%
OneCare Connect	6,785	7,599	814	10 7%
OneCare	380	529	150	28 3%
PACE	466	666	200	30 0%
Total	$ 40,326	$ 50,981	$ 10,656	20 9%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	3,726	4,183	457
OneCare Connect	878	936	58
OneCare	18	24	6
PACE	238	301	63
Total	4,861	5,444	583

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	815	735	80
OneCare Connect	67	64	3
OneCare	300	221	80
PACE	5	4	1
Total	1,187	1,023	164

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended October 31, 2018

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	772,846		784,348		(11,502)	
REVENUE						
Medi-Cal	$ 246,545,636	$ 325.91	$ 249,039,040	$ 324.33	$ (2,493,405)	$ 1.58
OneCare Connect	21,457,919	1,463 21	24,817,709	1,667.97	(3,359,790)	(204.76)
OneCare	1,419,685	1,011 17	1,607,996	1,214.50	(188,311)	(203.33)
PACE	2,136,015	7,391.06	2,098,923	7,237.67	37,092	153.39
Total Operating Revenue	271,559,256	351.38	277,563,668	353.88	(6,004,413)	(2.50)
MEDICAL EXPENSES						
Medi-Cal	233,243,986	308.32	239,035,817	311.30	5,791,831	2.98
OneCare Connect	24,235,190	1,652 59	24,277,933	1,631.69	42,743	(20.90)
OneCare	1,745,557	1,243 27	1,549,359	1,170.21	(196,198)	(73.06)
PACE	1,964,037	6,795 97	1,943,530	6,701.83	(20,507)	(94.14)
Total Medical Expenses	261,188,770	337.96	266,806,639	340.16	5,617,869	2.20
GROSS MARGIN	10,370,485	13.42	10,757,029	13.72	(386,544)	(0.30)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,129,143	9.22	8,599,587	10.96	1,470,444	1.74
Professional fees	225,114	0.29	412,333	0.53	187,219	0.24
Purchased services	781,102	1.01	1,235,014	1.57	453,911	0.56
Printing & Postage	459,298	0.59	533,146	0.68	73,848	0.09
Depreciation & Amortization	368,695	0.48	464,166	0.59	95,470	0.11
Other expenses	1,158,325	1.50	1,581,992	2.02	423,668	0.52
Indirect cost allocation & Occupancy expense	293,089	0.38	372,234	0.47	79,144	0.09
Total Administrative Expenses	10,414,766	13.48	13,198,471	16.83	2,783,705	3.35
INCOME (LOSS) FROM OPERATIONS	(44,280)	(0.06)	(2,441,442)	(3.11)	2,397,161	3.05
INVESTMENT INCOME						
Interest income	2,790,508	3.61	416,667	0.53	2,373,841	3.08
Realized gain/(loss) on investments	(168,595)	(0.22)	-	-	(168,595)	(0.22)
Unrealized gain/(loss) on investments	(558,069)	(0.72)	-	-	(558,069)	(0.72)
Total Investment Income	2,063,843	2.67	416,667	0.53	1,647,177	2.14
TOTAL GRANT INCOME	(3,460)	-	-	-	(3,460)	-
OTHER INCOME	12	-	-	-	12	-
CHANGE IN NET ASSETS	**2,016,115**	**2.61**	**(2,024,775)**	**(2.58)**	**4,040,890**	**5.19**
MEDICAL LOSS RATIO	**96.2%**		**96.1%**		**(0.1%)**	
ADMINISTRATIVE LOSS RATIO	**3.8%**		**4.8%**		**0.9%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2018

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	3,101,661		3,139,023		(37,362)	
REVENUE						
Medi-Cal	$ 984,847,974	$ 324.38	$ 991,194,200	$ 322.55	$ (6,346,226)	$ 1.83
OneCare Connect	99,980,885	1,697.99	99,599,304	1,671.16	381,581	26.83
OneCare	5,128,686	923.59	6,365,647	1,201.97	(1,236,962)	(278.38)
PACE	8,379,541	7,389.37	8,119,173	7,242.79	260,368	146.58
Total Operating Revenue	1,098,337,086	354.11	1,105,278,324	352.11	(6,941,237)	2.00
MEDICAL EXPENSES						
Medi-Cal	932,367,558	307.09	944,013,565	307.20	11,646,006	0.11
OneCare Connect	95,641,643	1,624.29	96,229,749	1,614.62	588,106	(9.67)
OneCare	6,003,390	1,081.11	6,109,900	1,153.68	106,510	72.57
PACE	7,069,483	6,234.11	7,421,987	6,620.86	352,504	386.75
Total Medical Expenses	1,041,082,075	335.65	1,053,775,200	335.70	12,693,126	0.05
GROSS MARGIN	57,255,012	18.46	51,503,124	16.41	5,751,888	2.05
ADMINISTRATIVE EXPENSES						
Salaries and benefits	27,005,008	8.71	32,585,680	10.38	5,580,672	1.67
Professional fees	842,625	0.27	1,649,333	0.53	806,708	0.26
Purchased services	3,322,763	1.07	4,942,552	1.57	1,619,789	0.50
Printing & Postage	1,510,570	0.49	2,132,581	0.68	622,011	0.19
Depreciation & Amortization	1,572,708	0.51	1,856,665	0.59	283,957	0.08
Other expenses	4,652,920	1.50	6,325,474	2.02	1,672,554	0.52
Indirect cost allocation & Occupancy expense	1,418,918	0.46	1,488,934	0.47	70,016	0.01
Total Administrative Expenses	40,325,512	13.00	50,981,219	16.24	10,655,707	3.24
INCOME (LOSS) FROM OPERATIONS	16,929,500	5.46	521,905	0.17	16,407,595	5.29
INVESTMENT INCOME						
Interest income	10,147,418	3.27	1,666,667	0.53	8,480,752	2.74
Realized gain/(loss) on investments	(823,669)	(0.27)	-	-	(823,669)	(0.27)
Unrealized gain/(loss) on investments	(639,542)	(0.21)	-	-	(639,542)	(0.21)
Total Investment Income	8,684,208	2.80	1,666,667	0.53	7,017,541	2.27
TOTAL GRANT INCOME	(3,460)	-	-	-	(3,460)	-
OTHER INCOME	592	-	-	-	592	-
CHANGE IN NET ASSETS	**25,610,839**	**8.26**	**2,188,572**	**0.70**	**23,422,267**	**7.56**
MEDICAL LOSS RATIO	**94 8%**		**95.3%**		**0.6%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.6%**		**0.9%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended October 31, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	518,823	237,665	756,488	14,665	1,404	289	772,846
REVENUES							
Capitation Revenue	$ 136,091,545	$ 110,454,091	$ 246,545,636	$ 21,457,919	$ 1,419,685	$ 2,136,015	$ 271,559,256
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	136,091,545	110,454,091	246,545,636	21,457,919	1,419,685	2,136,015	271,559,256
MEDICAL EXPENSES							
Provider Capitation	35,418,123	50,629,882	86,048,005	11,226,570	401,588		97,676,163
Facilities	23,187,964	23,670,684	46,858,648	3,494,523	695,246	604,273	51,652,690
Ancillary	-	-	-	767,461	69,776	-	837,237
Professional Claims	16,925,328	6,136,746	23,062,074	-	-	367,045	23,429,118
Prescription Drugs	17,615,095	20,268,875	37,883,970	5,465,037	454,076	181,487	43,984,569
MLTSS	31,579,548	2,703,703	34,283,252	1,620,102	67,956	(1,808)	35,969,501
Medical Management	1,762,028	1,126,399	2,888,426	1,148,988	54,498	667,870	4,759,782
Quality Incentives	774,166	412,842	1,187,008	281,000		2,890	1,470,898
Reinsurance & Other	471,125	561,480	1,032,604	231,511	2,416	142,280	1,408,811
Total Medical Expenses	127,733,376	105,510,610	233,243,986	24,235,190	1,745,557	1,964,037	261,188,770
Medical Loss Ratio	**93.9%**	**95.5%**	**94.6%**	**112.9%**	**123.0%**	**91.9%**	**96.2%**
GROSS MARGIN	**8,358,169**	**4,943,481**	**13,301,650**	**(2,777,271)**	**(325,872)**	**171,979**	**10,370,485**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			6,225,554	771,277	32,764	99,548	7,129,143
Professional fees			174,593	36,113	14,666	(259)	225,114
Purchased services			589,201	170,707	1,706	19,489	781,102
Printing & Postage			277,796	155,415	26,083	4	459,298
Depreciation & Amortization			366,624			2,072	368,695
Other expenses			1,106,600	46,538		5,187	1,158,325
Indirect cost allocation & Occupancy			(521,663)	798,228	11,794	4,731	293,089
Total Administrative Expenses			8,218,705	1,978,277	87,013	130,771	10,414,766
Admin Loss Ratio			**3.3%**	**9.2%**	**6.1%**	**6.1%**	**3.8%**
INCOME (LOSS) FROM OPERATIONS			5,082,945	(4,755,548)	(412,884)	41,207	(44,280)
INVESTMENT INCOME							2,063,843
TOTAL GRANT INCOME			(3,460)				(3,460)
OTHER INCOME			12				12
CHANGE IN NET ASSETS			**$ 5,079,496**	**$ (4,755,548)**	**$ (412,884)**	**$ 41,207**	**$ 2,016,115**
BUDGETED CHANGE IN NET ASSETS			(936,963)	(1,394,773)	(75,250)	(34,456)	(2,024,775)
VARIANCE TO BUDGET - FAV (UNFAV)			$ 6,016,460	$ (3,360,775)	$ (337,635)	$ 75,663	$ 4,040,890

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ended October 31, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	2,084,938	951,154	3,036,092	58,882	5,553	1,134	3,101,661
REVENUES							
Capitation Revenue	$ 541,401,572	$ 443,446,402	$ 984,847,974	$ 99,980,885	$ 5,128,686	$ 8,379,541	1,098,337,086
Other Income	-	-	-	-	-	-	-
Total Operating Revenue	541,401,572	443,446,402	984,847,974	99,980,885	5,128,686	8,379,541	1,098,337,086
MEDICAL EXPENSES							
Provider Capitation	143,031,220	200,904,160	343,935,379	46,689,127	1,235,988		391,860,494
Facilities	94,219,636	93,418,826	187,638,461	12,715,639	2,249,413	1,742,422	204,345,935
Ancillary	-	-	-	2,358,108	134,180	-	2,492,289
Professional Claims	65,406,859	25,797,795	91,204,654	-	-	1,640,000	92,844,654
Prescription Drugs	69,386,432	78,965,277	148,351,710	21,709,616	1,759,718	616,270	172,437,313
MLTSS	129,853,861	11,415,297	141,269,158	5,746,459	382,863	(843)	147,397,637
Medical Management	7,863,982	3,957,989	11,821,970	4,382,288	220,949	2,390,406	18,815,614
Quality Incentives	3,090,272	1,630,697	4,720,968	1,122,480		11,340	5,854,788
Reinsurance & Other	2,096,792	1,328,466	3,425,258	917,926	20,278	669,889	5,033,352
Total Medical Expenses	514,949,052	417,418,506	932,367,558	95,641,643	6,003,390	7,069,483	1,041,082,075
Medical Loss Ratio	**95.1%**	**94.1%**	**94.7%**	**95.7%**	**117.1%**	**84.4%**	**94.8%**
GROSS MARGIN	**26,452,520**	**26,027,896**	**52,480,416**	**4,339,242**	**(874,704)**	**1,310,059**	**57,255,012**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits			23,472,993	3,036,889	120,676	374,449	27,005,008
Professional fees			680,879	103,003	58,667	77	842,625
Purchased services			2,504,511	722,515	52,033	43,704	3,322,763
Printing & Postage			1,177,872	279,916	31,701	21,082	1,510,570
Depreciation & Amortization			1,564,414			8,294	1,572,708
Other expenses			4,475,742	172,658	60	4,460	4,652,920
Indirect cost allocation & Occupancy			(1,182,313)	2,470,410	116,689	14,133	1,418,918
Total Administrative Expenses			32,694,097	6,785,391	379,825	466,199	40,325,512
Admin Loss Ratio			**3.3%**	**6.8%**	**7.4%**	**5.6%**	**3.7%**
INCOME (LOSS) FROM OPERATIONS			19,786,318	(2,446,149)	(1,254,529)	843,860	16,929,500
INVESTMENT INCOME							8,684,208
TOTAL GRANT INCOME			(3,460)				(3,460)
OTHER INCOME			592				592
CHANGE IN NET ASSETS			**$ 19,783,450**	**$ (2,446,149)**	**$ (1,254,529)**	**$ 843,860**	**$ 25,610,839**
BUDGETED CHANGE IN NET ASSETS			4,994,353	(4,229,547)	(273,721)	30,820	2,188,572
VARIANCE TO BUDGET - FAV (UNFAV)			$ 14,789,096	$ 1,783,398	$ (980,808)	$ 813,040	$ 23,422,267

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $2.0 million, $4.0 million favorable to budget
- Operating income is $2.4 million favorable to budget, with a surplus in non-operating income of $2.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $25.6 million, $23.4 million favorable to budget
- Operating surplus is $16.9 million, with a surplus in non-operating of $8.7 million

Change in Net Assets by Line of Business (LOB) ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
5.1	(0.9)	6.0	Medi-Cal	19.8	5.0	14.8
(4.8)	(1.4)	(3.4)	OCC	(2.4)	(4.2)	1.8
(0.4)	(0.1)	(0.3)	OneCare	(1.3)	(0.3)	(1.0)
0.0	(0.0)	0.1	PACE	0.8	0.0	0.8
(0.0)	**(2.4)**	**2.4**	**Operating**	**16.9**	**0.5**	**16.4**
2.1	0.4	1.6	Inv./Rental Inc, MCO tax	8.7	1.7	7.0
2.1	**0.4**	**1.6**	**Non-Operating**	**8.7**	**1.7**	**7.0**
2.0	**(2.0)**	**4.0**	**TOTAL**	**25.6**	**2.2**	**23.4**

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CalOptima - Consolidated
Enrollment Summary
For the Four Months Ended October 31, 2018

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
64,015	64,443	(428)	(0.7%)	Aged	255,311	256,428	(1,117)	(0.4%)
596	620	(24)	(3.9%)	BCCTP	2,458	2,480	(22)	(0.9%)
46,935	47,131	(196)	(0.4%)	Disabled	188,036	188,470	(434)	(0.2%)
310,181	315,152	(4,971)	(1.6%)	TANF Child	1,248,996	1,263,723	(14,727)	(1.2%)
93,667	94,783	(1,116)	(1.2%)	TANF Adult	376,566	381,208	(4,642)	(1.2%)
3,429	3,482	(53)	(1.5%)	LTC	13,571	13,862	(291)	(2.1%)
237,665	242,244	(4,579)	(1.9%)	MCE	951,154	966,836	(15,682)	(1.6%)
756,488	**767,855**	**(11,367)**	**(1.5%)**	**Medi-Cal**	**3,036,092**	**3,073,007**	**(36,915)**	**(1.2%)**
14,665	**14,879**	**(214)**	**(1.4%)**	**OneCare Connect**	**58,882**	**59,599**	**(717)**	**(1.2%)**
289	**290**	**(1)**	**(0.3%)**	**PACE**	**1,134**	**1,121**	**13**	**1.2%**
1,404	**1,324**	**80**	**6.0%**	**OneCare**	**5,553**	**5,296**	**257**	**4.9%**
772,846	**784,348**	**(11,502)**	**(1.5%)**	**CalOptima Total**	**3,101,661**	**3,139,023**	**(37,362)**	**(1.2%)**

				Enrollment (By Network)				
167,942	167,977	(35)	(0.0%)	HMO	669,057	672,993	(3,936)	(0.6%)
219,407	222,172	(2,765)	(1.2%)	PHC	872,805	889,077	(16,272)	(1.8%)
194,290	191,730	2,560	1.3%	Shared Risk Group	772,764	771,760	1,004	0.1%
174,849	185,976	(11,127)	(6.0%)	Fee for Service	721,466	739,177	(17,711)	(2.4%)
756,488	**767,855**	**(11,367)**	**(1.5%)**	**Medi-Cal**	**3,036,092**	**3,073,007**	**(36,915)**	**(1.2%)**
14,665	**14,879**	**(214)**	**(1.4%)**	**OneCare Connect**	**58,882**	**59,599**	**(717)**	**(1.2%)**
289	**290**	**(1)**	**(0.3%)**	**PACE**	**1,134**	**1,121**	**13**	**1.2%**
1,404	**1,324**	**80**	**6.0%**	**OneCare**	**5,553**	**5,296**	**257**	**4.9%**
772,846	**784,348**	**(11,502)**	**(1.5%)**	**CalOptima Total**	**3,101,661**	**3,139,023**	**(37,362)**	**(1.2%)**

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CalOptima - Consolidated
Enrollment Trend by Network Type
Fiscal Year 2019

Network Type	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	MMs
HMO													
Aged	3,844	3,866	3,841	3,841									15,392
BCCTP	1	1	1	1									4
Disabled	6,744	6,789	6,789	6,811									27,133
TANF Child	58,435	58,267	58,162	58,110									232,974
TANF Adult	29,473	29,373	29,404	29,529									117,779
LTC	2	2	3	4									11
MCE	68,597	68,602	68,919	69,646									275,764
	167,096	**166,900**	**167,119**	**167,942**									**669,057**
PHC													
Aged	1,600	1,621	1,620	1,673									6,514
BCCTP	-	-	-	-									-
Disabled	7,243	7,239	7,230	7,212									28,924
TANF Child	157,157	156,755	157,444	158,169									629,525
TANF Adult	12,731	12,684	12,787	12,785									50,987
LTC	-	1	-	-									1
MCE	39,060	38,992	39,234	39,568									156,854
	217,791	**217,292**	**218,315**	**219,407**									**872,805**
Shared Risk Group													
Aged	3,593	3,605	3,621	3,642									14,461
BCCTP	-	-	-	-									-
Disabled	7,626	7,554	7,486	7,473									30,139
TANF Child	67,471	67,226	67,159	67,251									269,107
TANF Adult	30,936	30,567	30,622	30,670									122,795
LTC	2	-	1	1									4
MCE	83 554	83 443	84 008	85 253									336 258
	193,182	**192,395**	**192,897**	**194,290**									**772,764**
Fee for Service (Dual)													
Aged	49,903	50,943	50,657	50,741									202,244
BCCTP	16	15	18	14									63
Disabled	20,706	20,863	20,741	20,761									83,071
TANF Child	2	3	2	2									9
TANF Adult	1,081	1,083	1,064	1,055									4,283
LTC	3,025	3,019	3,007	3,077									12,128
MCE	2,327	2,367	2,416	2,388									9,498
	77,060	**78,293**	**77,905**	**78,038**									**311,296**
Fee for Service (Non-Dual)													
Aged	4,702	3,727	4,153	4,118									16,700
BCCTP	613	596	601	581									2,391
Disabled	4,802	4,672	4,617	4,678									18,769
TANF Child	30,166	31,801	28,765	26,649									117,381
TANF Adult	20,308	20,588	20,198	19,628									80,722
LTC	353	360	367	347									1,427
MCE	44,399	44,410	43,161	40,810									172,780
	105,343	**106,154**	**101,862**	**96,811**									**410,170**
MEDI-CAL TOTAL													
Aged	63,642	63,762	63,892	64,015									255,311
BCCTP	630	612	620	596									2,458
Disabled	47,121	47,117	46,863	46,935									188,036
TANF Child	313,231	314,052	311,532	310,181									1,248,996
TANF Adult	94,529	94,295	94,075	93,667									376,566
LTC	3,382	3,382	3,378	3,429									13,571
MCE	237 937	237 814	237 738	237 665									951 154
	760,472	**761,034**	**758,098**	**756,488**									**3,036,092**
PACE	273	286	286	289									1,134
OneCare	1,390	1,384	1,375	1,404									5,553
OneCare Connect	16,399	13,137	14,681	14,665									58,882
TOTAL	**778,534**	**775,841**	**774,440**	**772,846**									**3,101,661**

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ENROLLMENT:

Overall October enrollment was 772,846

- Unfavorable to budget 11,502 or 1.5%
- Decreased 1,594 or 0.2% from prior month (September 2018)
- Decreased 7,799 or 1.0% from prior year (October 2017)

Medi-Cal enrollment was 756,488

- Unfavorable to budget 11,367
    - Temporary Assistance for Needy Families (TANF) unfavorable 6,087
    - Medi-Cal Expansion (MCE) unfavorable 4,579
    - Seniors and Persons with Disabilities (SPD) unfavorable 648
    - Long-Term Care (LTC) unfavorable 53
- Decreased 1,610 from prior month

OneCare Connect enrollment was 14,665

- Unfavorable to budget 214
- Decreased 16 from prior month

OneCare enrollment was 1,404

- Favorable to budget 80
- Increased 29 from prior month

PACE enrollment was 289

- Unfavorable to budget 1
- Increased 3 from prior month

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
756,488	**767,855**	**(11,367)**	**(1.5%)**	**Member Months**	**3,036,092**	**3,073,007**	**(36,915)**	**(1.2%)**
				Revenues				
246,545,636	249,039,040	(2,493,405)	(1 0%)	Capitation revenue	984,847,974	991,194,200	(6,346,226)	(0 6%)
-	-	-	0 0%	Other income	-	-	-	0 0%
246,545,636	**249,039,040**	**(2,493,405)**	**(1.0%)**	**Total Operating Revenue**	**984,847,974**	**991,194,200**	**(6,346,226)**	**(0.6%)**
				Medical Expenses				
87,235,013	84,817,632	(2,417,380)	(2 9%)	Provider capitation	348,656,347	338,225,063	(10,431,285)	(3 1%)
46,858,648	44,054,393	(2,804,255)	(6 4%)	Facilities	187,638,461	174,733,229	(12,905,232)	(7 4%)
23,062,074	29,384,670	6,322,597	21 5%	Professional Claims	91,204,654	112,761,274	21,556,620	19 1%
37,883,970	39,477,201	1,593,231	4 0%	Prescription drugs	148,351,710	155,877,905	7,526,195	4 8%
34,283,252	36,941,146	2,657,895	7 2%	MLTSS	141,269,158	145,726,020	4,456,862	3 1%
2,888,426	3,830,141	941,715	24 6%	Medical management	11,821,970	14,567,538	2,745,567	18 8%
1,032,604	530,634	(501,970)	(94 6%)	Reinsurance & other	3,425,258	2,122,536	(1,302,722)	(61 4%)
233,243,986	**239,035,817**	**5,791,831**	**2.4%**	**Total Medical Expenses**	**932,367,558**	**944,013,565**	**11,646,006**	**1.2%**
13,301,650	**10,003,223**	**3,298,427**	**33.0%**	**Gross Margin**	**52,480,416**	**47,180,635**	**5,299,781**	**11.2%**
				Administrative Expenses				
6,225,554	7,489,382	1,263,828	16 9%	Salaries, wages & employee benefits	23,472,993	28,383,062	4,910,069	17 3%
174,593	349,650	175,056	50 1%	Professional fees	680,879	1,398,600	717,721	51 3%
589,201	945,147	355,945	37 7%	Purchased services	2,504,511	3,783,085	1,278,574	33 8%
277,796	423,310	145,514	34 4%	Printing and postage	1,177,872	1,693,238	515,366	30 4%
366,624	462,075	95,451	20 7%	Depreciation and amortization	1,564,414	1,848,302	283,888	15 4%
1,106,600	1,494,214	387,614	25 9%	Other operating expenses	4,475,742	5,974,360	1,498,618	25 1%
(521,663)	(223,591)	298,072	133 3%	Indirect cost allocation, Occupancy Expense	(1,182,313)	(894,365)	287,948	32 2%
8,218,705	**10,940,186**	**2,721,481**	**24.9%**	**Total Administrative Expenses**	**32,694,097**	**42,186,282**	**9,492,184**	**22.5%**
				Operating Tax				
10,613,717	10,773,006	(159,289)	(1 5%)	Tax Revenue	42,596,614	43,114,288	(517,674)	(1 2%)
10,613,717	10,773,006	159,289	1 5%	Premium tax expense	42,596,614	32,330,150	(10,266,464)	(31 8%)
-	-	-	0 0%	Sales tax expense	-	10,784,138	10,784,138	100 0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
				Grant Income				
42,634	249,874	(207,240)	(82 9%)	Grant Revenue	240,666	999,496	(758,830)	(75 9%)
28,050	223,107	195,057	87 4%	Grant expense - Service Partner	170,850	892,428	721,578	80 9%
18,045	26,767	8,722	32 6%	Grant expense - Administrative	73,277	107,068	33,791	31 6%
(3,460)	-	(3,460)	**0.0%**	**Total Grant Income**	(3,460)	-	(3,460)	**0.0%**
-	**-**	**-**	**0.0%**	**QAF and IGT - Net**	**(0)**	**-**	**(0)**	**0.0%**
12	**-**	**12**	**0.0%**	**Other income**	**592**	**-**	**592**	**0.0%**
12	-	12	0 0%	MC Other income	592	-	592	0 0%
5,079,496	**(936,963)**	**6,016,460**	**642.1%**	**Change in Net Assets**	**19,783,450**	**4,994,353**	**14,789,096**	**296.1%**
94.6%	***96.0%***	***1.4%***	***1.4%***	***Medical Loss Ratio***	***94.7%***	***95.2%***	***0.6%***	***0.6%***
3.3%	***4.4%***	***1.1%***	***24.1%***	***Admin Loss Ratio***	***3.3%***	***4.3%***	***0.9%***	***22.0%***

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MEDI-CAL INCOME STATEMENT – OCTOBER MONTH:

REVENUES of $246.5 million are unfavorable to budget $2.5 million, driven by:

- Unfavorable volume related variance of $3.7 million
- Favorable price related variance of $1.2 million

MEDICAL EXPENSES are $233.2 million, favorable to budget $5.8 million due to:

- **Professional Claims** expense is favorable to budget $6.3 million due to Child Health and Disability Prevention Program (CHDP) expenses of $2.3 million, Behavioral Health Treatment (BHT) expenses of $2.1 million, Proposition 56 expenses of $2.6 million, offset by Incurred But Not Reported (IBNR) expenses of ($0.8) million. Actual CHDP and Proposition 56 expenses reported in Provider Capitation
- **Facilities** expense is unfavorable to budget $2.8 million due to crossover claims of $1.0 million, outpatient claims totaling $0.7 million and shared risk pool of $0.8 million
- **Managed Long Term Services and Supports (MLTSS)** expenses favorable to budget $2.7 million due to IBNR
- **Provider Capitation** expense is unfavorable to budget $2.4 million due to Proposition 56 and CHDP expenses that were budgeted in Professional Claims
- **Prescription Drug** expense is favorable to budget $1.2 million

ADMINISTRATIVE EXPENSES are $8.2 million, favorable to budget $2.7 million, driven by:

- **Salary & Benefits**: $1.3 million favorable to budget from open positions
- **Purchased Services**: $0.4 million favorable to budget
- **Other Non-Salary**: $1.1 million favorable to budget

CHANGE IN NET ASSETS is $5.1 million for the month, $6.0 million favorable to budget

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Four Months Ending October 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,665	**14,879**	**(214)**	**(1.4%)**	**Member Months**	**58,882**	**59,599**	**(717)**	**(1.2%)**
				Revenues				
2,508,207	3,299,053	(790,846)	(24 0%)	Medi-Cal Capitation revenue	10,423,995	13,357,445	(2,933,450)	(22 0%)
16,699,618	16,828,008	(128,390)	(0 8%)	Medicare Capitation revenue part C	69,091,461	67,452,466	1,638,995	2 4%
2,250,094	4,690,648	(2,440,554)	(52 0%)	Medicare Capitation revenue part D	20,465,429	18,789,393	1,676,036	8 9%
-	-	-	0 0%	Other Income	-	-	-	0 0%
21,457,919	**24,817,709**	**(3,359,790)**	**(13.5%)**	**Total Operating Revenue**	**99,980,885**	**99,599,304**	**381,581**	**0.4%**
				Medical Expenses				
11,507,570	11,429,861	(77,709)	(0 7%)	Provider capitation	47,811,607	45,369,962	(2,441,645)	(5 4%)
3,494,523	3,616,204	121,681	3 4%	Facilities	12,715,639	14,353,965	1,638,326	11 4%
767,461	658,637	(108,824)	(16 5%)	Ancillary	2,358,108	2,598,530	240,422	9 3%
1,620,102	1,683,130	63,028	3 7%	Long Term Care	5,746,459	6,785,552	1,039,093	15 3%
5,465,037	5,369,142	(95,895)	(1 8%)	Prescription drugs	21,709,616	21,243,389	(466,227)	(2 2%)
1,148,988	1,371,979	222,991	16 3%	Medical management	4,382,288	5,277,685	895,397	17 0%
231,511	148,980	(82,531)	(55 4%)	Other medical expenses	917,926	600,666	(317,260)	(52 8%)
24,235,190	**24,277,933**	**42,743**	**0.2%**	**Total Medical Expenses**	**95,641,643**	**96,229,749**	**588,106**	**0.6%**
(2,777,271)	**539,776**	**(3,317,047)**	**(614.5%)**	**Gross Margin**	**4,339,242**	**3,369,555**	**969,687**	**28.8%**
				Administrative Expenses				
771,277	919,585	148,308	16 1%	Salaries, wages & employee benefits	3,036,889	3,539,247	502,357	14 2%
36,113	42,917	6,804	15 9%	Professional fees	103,003	171,667	68,664	40 0%
170,707	251,415	80,709	32 1%	Purchased services	722,515	1,005,660	283,145	28 2%
155,415	86,202	(69,213)	(80 3%)	Printing and postage	279,916	344,807	64,891	18 8%
-	-	-	0 0%	Depreciation & amortization	-	-	-	0 0%
46,538	77,036	30,498	39 6%	Other operating expenses	172,658	308,146	135,488	44 0%
798,228	557,394	(240,834)	(43 2%)	Indirect cost allocation	2,470,410	2,229,576	(240,834)	(10 8%)
1,978,277	**1,934,549**	**(43,728)**	**(2.3%)**	**Total Administrative Expenses**	**6,785,391**	**7,599,102**	**813,711**	**10.7%**
				Operating Tax				
-	-	-	0 0%	Tax Revenue	-	-	-	0 0%
-	-	-	0 0%	Premium tax expense	-	-	-	0 0%
-	-	-	0 0%	Sales tax expense	-	-	-	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
(4,755,548)	**(1,394,773)**	**(3,360,775)**	**(241.0%)**	**Change in Net Assets**	**(2,446,149)**	**(4,229,547)**	**1,783,398**	**42.2%**
112.9%	***97.8%***	***(15.1%)***	***(15.5%)***	***Medical Loss Ratio***	***95.7%***	***96.6%***	***1.0%***	***1.0%***
9.2%	***7.8%***	***(1.4%)***	***(18.3%)***	***Admin Loss Ratio***	***6.8%***	***7.6%***	***0.8%***	***11.0%***

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ONECARE CONNECT INCOME STATEMENT – OCTOBER MONTH:

REVENUES of $21.5 million are unfavorable to budget $3.4 million due to unfavorable volume variance of $0.4 million and unfavorable price variance of $3.0 million due to calendar year 2017 Part D reconciliation

MEDICAL EXPENSES of $24.2 million are in line with budgeted amount of $24.3 million

ADMINISTRATIVE EXPENSES of $2.0 million are unfavorable to budgeted amount of $1.9 million

CHANGE IN NET ASSETS is ($4.8) million, $3.4 million unfavorable to budget

CalOptima
OneCare
Statement of Revenues and Expenses
For the Four Months Ending October, 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,404	**1,324**	**80**	**6.0%**	**Member Months**	**5,553**	**5,296**	**257**	**4.9%**
				Revenues				
1,028,633	1,103,743	(75,110)	(6 8%)	Medicare Part C revenue	3,167,422	4,369,019	(1,201,596)	(27 5%)
391,052	504,253	(113,201)	(22 4%)	Medicare Part D revenue	1,961,264	1,996,629	(35,365)	(1 8%)
1,419,685	**1,607,996**	**(188,311)**	**(11.7%)**	**Total Operating Revenue**	**5,128,686**	**6,365,647**	**(1,236,962)**	**(19.4%)**
				Medical Expenses				
401,588	452,799	51,210	11 3%	Provider capitation	1,235,988	1,793,420	557,432	31 1%
695,246	524,911	(170,335)	(32 5%)	Inpatient	2,249,413	2,059,236	(190,177)	(9 2%)
69,776	56,227	(13,550)	(24 1%)	Ancillary	134,180	219,787	85,607	38 9%
67,956	26,857	(41,099)	(153 0%)	Skilled nursing facilities	382,863	106,563	(276,300)	(259 3%)
454,076	447,240	(6,835)	(1 5%)	Prescription drugs	1,759,718	1,767,493	7,775	0 4%
54,498	34,759	(19,739)	(56 8%)	Medical management	220,949	137,154	(83,795)	(61 1%)
2,416	6,565	4,149	63 2%	Other medical expenses	20,278	26,246	5,968	22 7%
1,745,557	**1,549,359**	**(196,198)**	**(12.7%)**	**Total Medical Expenses**	**6,003,390**	**6,109,900**	**106,510**	**1.7%**
(325,872)	**58,637**	**(384,509)**	**(655.7%)**	**Gross Margin**	**(874,704)**	**255,748**	**(1,130,452)**	**(442.0%)**
				Administrative Expenses				
32,764	41,808	9,044	21 6%	Salaries, wages & employee benefits	120,676	161,151	40,476	25 1%
14,666	19,600	4,934	25 2%	Professional fees	58,667	78,400	19,733	25 2%
1,706	17,425	15,719	90 2%	Purchased services	52,033	69,700	17,667	25 3%
26,083	13,206	(12,877)	(97 5%)	Printing and postage	31,701	52,824	21,123	40 0%
-	6,883	6,883	100 0%	Other operating expenses	60	27,533	27,473	99 8%
11,794	34,965	23,171	66 3%	Indirect cost allocation, occupancy expens	116,689	139,860	23,171	16 6%
87,013	**133,887**	**46,874**	**35.0%**	**Total Administrative Expenses**	**379,825**	**529,468**	**149,644**	**28.3%**
(412,884)	**(75,250)**	**(337,635)**	**(448.7%)**	**Change in Net Assets**	**(1,254,529)**	**(273,721)**	**(980,808)**	**(358.3%)**
123.0%	***96.4%***	***(26.6%)***	***(27.6%)***	***Medical Loss Ratio***	***117.1%***	***96.0%***	***(21.1%)***	***(22.0%)***
6.1%	***8.3%***	***2.2%***	***26.4%***	***Admin Loss Ratio***	***7.4%***	***8.3%***	***0.9%***	***11.0%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Four Months Ending October, 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
289	**290**	**(1)**	**(0.3%)**	**Member Months**	**1,134**	**1,121**	**13**	**1.2%**
				Revenues				
1,593,718	1,624,063	(30,345)	(1 9%)	Medi-Cal capitation revenue	6,299,467	6,275,733	23,734	0 4%
420,609	381,843	38,766	10 2%	Medicare Part C revenue	1,610,526	1,483,450	127,076	8 6%
121,689	93,017	28,672	30 8%	Medicare Part D revenue	469,548	359,990	109,558	30 4%
2,136,015	**2,098,923**	**37,092**	**1.8%**	**Total Operating Revenue**	**8,379,541**	**8,119,173**	**260,368**	**3.2%**
				Medical Expenses				
667,870	729,357	61,487	8 4%	Medical Management	2,390,406	2,762,605	372,199	13 5%
604,273	436,515	(167,758)	(38 4%)	Claims payments to hospitals	1,742,422	1,671,709	(70,713)	(4 2%)
367,045	465,058	98,013	21 1%	Professional claims	1,640,000	1,792,287	152,287	8 5%
142,280	129,279	(13,001)	(10 1%)	Patient transportation	669,889	499,730	(170,159)	(34 1%)
181,487	167,885	(13,602)	(8 1%)	Prescription drugs	616,270	645,813	29,543	4 6%
(1,808)	12,586	14,394	114 4%	MLTSS	(843)	38,743	39,586	102 2%
2,890	2,850	(40)	(1 4%)	Other Expenses	11,340	11,100	(240)	(2 2%)
1,964,037	**1,943,530**	**(20,507)**	**(1.1%)**	**Total Medical Expenses**	**7,069,483**	**7,421,987**	**352,504**	**4.7%**
171,979	**155,393**	**16,586**	**10.7%**	**Gross Margin**	**1,310,059**	**697,186**	**612,873**	**87.9%**
				Administrative Expenses				
99,548	148,812	49,265	33 1%	Salaries, wages & employee benefits	374,449	502,220	127,770	25 4%
(259)	167	425	255 2%	Professional fees	77	667	589	88 4%
19,489	21,027	1,538	7 3%	Purchased services	43,704	84,107	40,403	48 0%
4	10,428	10,424	100 0%	Printing and postage	21,082	41,713	20,632	49 5%
2,072	2,091	19	0 9%	Depreciation & amortization	8,294	8,363	69	0 8%
5,187	3,859	(1,328)	(34 4%)	Other operating expenses	4,460	15,435	10,975	71 1%
4,731	3,466	(1,265)	(36 5%)	Indirect cost allocation, Occupancy Expense	14,133	13,863	(270)	(1 9%)
130,771	**189,849**	**59,077**	**31.1%**	**Total Administrative Expenses**	**466,199**	**666,366**	**200,167**	**30.0%**
				Operating Tax				
4,034	-	4,034	0 0%	Tax Revenue	15,831	-	15,831	0 0%
4,034	-	(4,034)	0 0%	Premium tax expense	15,831	-	(15,831)	0 0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
41,207	**(34,456)**	**75,663**	**219.6%**	**Change in Net Assets**	**843,860**	**30,820**	**813,040**	**2638.1%**
91.9%	***92.6%***	***0.6%***	***0.7%***	***Medical Loss Ratio***	***84.4%***	***91.4%***	***7.0%***	***7.7%***
6.1%	***9.0%***	***2.9%***	***32.3%***	***Admin Loss Ratio***	***5.6%***	***8.2%***	***2.6%***	***32.2%***

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CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2018

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
31,507	22,982	(8,525)	(37.1%)	Purchase services	135,405	91,927	(43,478)	(47.3%)
160,982	162,934	1,952	1.2%	Depreciation & amortization	644,442	651,738	7,296	1.1%
15,816	15,917	101	0.6%	Insurance expense	63,263	63,667	404	0.6%
122,580	173,136	50,556	29.2%	Repair and maintenance	414,047	692,544	278,497	40.2%
14,869	1,635	(13,234)	(809.4%)	Other Operating Expense	236,346	6,540	(229,806)	(3513.8%)
(345,755)	(376,604)	(30,849)	(8.2%)	Indirect allocation, Occupancy	(1,493,503)	(1,506,416)	(12,913)	(0.9%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

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OTHER STATEMENTS – OCTOBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($412.9) thousand, $337.6 thousand unfavorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $41.2 thousand, $75.7 thousand favorable to budget

CalOptima
Balance Sheet
October 31, 2018

ASSETS		LIABILITIES & FUND BALANCES	
Current Assets		Current Liabilities	
Operating Cash	$486,792,772	Accounts Payable	$13,692,368
Investments	459,590,795	Medical Claims liability	785,374,925
Capitation receivable	284,939,880	Accrued Payroll Liabilities	12,986,908
Receivables - Other	23,150,656	Deferred Revenue	86,238,097
Prepaid expenses	5,101,655	Deferred Lease Obligations	95,382
		Capitation and Withholds	122,420,262
Total Current Assets	**1,259,575,759**	**Total Current Liabilities**	**1,020,807,942**
Capital Assets			
Furniture & Equipment	34,328,849		
Building/Leasehold Improvements	8,506,283		
505 City Parkway West	49,743,943		
	92,579,074		
Less: accumulated depreciation	(43,305,932)		
Capital assets, net	49,273,142	Other (than pensions) post	
		employment benefits liability	25,058,410
Other Assets		Net Pension Liabilities	24,772,635
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	100,000
Board-designated assets			
Cash and Cash Equivalents	9,188,384	**TOTAL LIABILITIES**	**1,070,738,987**
Long-term Investments	531,840,438		
Total Board-designated Assets	541,028,822	Deferred Inflows	
		Change in Assumptions	3,329,380
Total Other Assets	541,328,822		
TOTAL ASSETS	**1,850,177,723**	TNE	83,204,015
		Funds in Excess of TNE	704,038,391
Deferred Outflows			
Pension Contributions	953,907		
Difference in Experience	1,365,903	Net Assets	787,242,406
Excess Earnings	1,017,387		
Changes in Assumptions	7,795,853		
TOTAL ASSETS & DEFERRED OUTFLOWS	**1,861,310,773**	**TOTAL LIABILITIES & FUND BALANCES**	**1,861,310,773**

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CalOptima
Board Designated Reserve and TNE Analysis
as of October 31, 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	148,122,642				
	Tier 1 - Logan Circle	147,939,189				
	Tier 1 - Wells Capital	147,420,805				
Board-designated Reserve		443,482,636	312,678,371	482,342,251	130,804,265	(38,859,615)
TNE Requirement	Tier 2 - Logan Circle	97,546,186	83,204,015	83,204,015	14,342,171	14,342,171
	Consolidated:	**541,028,823**	**395,882,386**	**565,546,266**	**145,146,436**	**(24,517,443)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
October 31, 2018

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,016,115	25,610,839
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	529,677	2,217,150
Changes in assets and liabilities:		
Prepaid expenses and other	323,857	1,195,691
Catastrophic reserves		
Capitation receivable	(7,029,304)	13,060,480
Medical claims liability	(7,909,017)	(47,244,688)
Deferred revenue	(470,083)	(27,464,852)
Payable to providers	8,003,973	25,971,371
Accounts payable	(22,563,370)	8,022,184
Other accrued liabilities	(91,091)	139,790
Net cash provided by/(used in) operating activities	(27,189,242)	1,507,964
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(11,513,634)	120,708,153
Change in Property and Equipment	(5,946)	(732,042)
Change in Board designated reserves	(547,592)	(2,781,150)
Net cash provided by/(used in) investing activities	(12,067,173)	117,194,961
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENT	(39,256,415)	118,702,925
CASH AND CASH EQUIVALENTS, beginning of period	526,049,187	368,089,847
CASH AND CASH EQUIVALENTS, end of period	**486,792,772**	**486,792,772**

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BALANCE SHEET:

ASSETS decreased $21.0 million from September or 1.1%

- **Operating Cash** decreased by $39.3 million or 7.5% driven by the quarterly tax payment of $34.1 million and capitation payment timing
- **Investments** increased $11.5 million or 2.6% due to timing of receipts and transfers for daily payments
- **Capitation Receivables** increased $8.5 million timing of capitation payments and revenue accruals

LIABILITIES decreased $23.0 million from September or 2.1%

- **Accounts Payable** decreased $23.7 due to the quarterly sales tax payment
- **Claims Liability** by line of business decreased $7.9 million due to timing of claim payments
- **Capitation Payable** increased $8.0 million due to increase in Risk Sharing reserve and Quality withhold

NET ASSETS are $787.2 million, an increase of $2.0 million from September

CalOptima Foundation
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2018

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	**Total Operating Revenue**	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	24,737	24,737	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	11,939	11,939	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
917	229,840	228,923	99.6%	Other	3,667	919,359	915,692	99.6%
917	239,009	238,092	99.6%	**Total Operating Expenditures**	3,667	956,035	952,368	99.6%
0	0	0	0.0%	**Investment Income**	305	0	(305)	0.0%
(917)	**(239,009)**	**(238,092)**	**(99.6%)**	**Program Income**	**(3,362)**	**(956,035)**	**(952,673)**	**(99.6%)**

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CalOptima Foundation
Balance Sheet
October 31, 2018

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,846,477	Accounts payable-Current	3,667
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	3,032
Total Current Assets	**2,846,477**	Grants-Foundation	0
		Total Current Liabilities	**6,699**
		Total Liabilities	**6,699**
		Net Assets	**2,839,778**
TOTAL ASSETS	**2,846,477**	**TOTAL LIABILITIES & NET ASSETS**	**2,846,477**

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CALOPTIMA FOUNDATION - OCTOBER MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees $0.9 thousand, $3.7 thousand year to date (YTD)

BALANCE SHEET:

ASSETS

- Cash of $2.8 million remains from the fiscal year (FY) 2014 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- $3.7 thousand for audit fees

NET INCOME is ($3.4) thousand YTD

Budget Allocation Changes
Reporting Changes for October 2018

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year

No Activity for October

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 parameter

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Board of Directors Meeting
December 6, 2018

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- Performance Measure Validation (PMV) Audit for Medicare-Medicaid Plans (MMPs): On May 21, 2018, CMS notified MMPs of upcoming efforts to validate that MMPs' reported data on performance measures are reliable, valid, complete, and comparable. The following elements will be validated for the 2017 measurement year for select core and state-specific performance measures:

  - MMP Core 2.1: Members with an assessment completed within 90 days of enrollment.

  - MMP CA 1.2: High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).

  - MMP CA 1.4: Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA).

  On September 17, 2018, CMS' auditors conducted validation activities on enrollment and eligibility data processes, assessment and care plan completion processes, performance measure production and reporting, and primary source verification of selected case samples for each of the three (3) performance measures. CalOptima anticipates the release of the preliminary findings in December 2018.

2. OneCare and OneCare Connect

- 2018 Data Integrity Testing (*applicable to OneCare Connect and OneCare*): As part of its audit readiness efforts, CalOptima has engaged an independent auditing consultant to perform validation of its universes for completeness and accuracy for select Part C core operational areas based on the final 2017 CMS Medicare Parts C and D Program Audit Protocols and the 2017 CMS Program Audit Protocols for MMPs. The data integrity testing was completed in September 2018 and remediation efforts are expected to continue through December 2018. CalOptima anticipates receiving the preliminary audit report by mid-December 2018.

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- 2019 CMS Readiness Checklist (*applicable to OneCare and OneCare Connect)*:
  On 10/2/18, CMS released the 2019 Readiness Checklist for Medicare Advantage organizations (e.g., OneCare) and MMPs (e.g., OneCare Connect). Plans are expected to ensure compliance with the operational requirements summarized in the Readiness Checklist for the 2019 benefit year. CalOptima's Regulatory Affairs & Compliance (RAC) department is leading the validation efforts to ensure business areas are compliant with the operational requirements in the Readiness Checklist by 1/1/19.

3. Medi-Cal

- 2018 Medi-Cal Audit:
  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 26, 2018 through March 9, 2018. The audit covered the period from February 1, 2017 through January 31, 2018. The audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. DHCS issued its final audit report on October 8, 2018. The final report contained one (1) finding in the area of case management and care coordination. Specifically, DHCS cited that the "Plan did not ensure that Behavioral Health Treatment (BHT) services were provided and supervised under a Plan-approved behavioral treatment plan that included a transition plan, crisis plan, and parent/caregiver training." On November 5, 2018, CalOptima submitted a Corrective Action Plan (CAP) response to DHCS to address the finding. The CAP details CalOptima's comprehensive remedial efforts to correct the finding, which included the creation of templates to ensure the inclusion of all required elements of the behavioral treatment plan; documented training for CalOptima staff and BHT providers on the use of the templates; related updates to a CalOptima policy; related updates to a CalOptima Frequently Asked Questions (FAQs) document; and technical changes to CalOptima's medical management system to ensure that all treatment plan requirements are captured during the prior authorization review process.

- 2019 Medi-Cal Audit:
  On November 8, 2018, DHCS informed CalOptima that it will conduct its annual audit of CalOptima's Medi-Cal program from February 4, 2019 through February 15, 2019. The audit will cover the review period of February 1, 2018 through January 31, 2019. The audit will consist of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of October 2018.

C. Updates on Internal and Health Network Audits

1. 2017-2018 Annual Internal Validation Audit

- CalOptima's Audit & Oversight department completed its annual internal validation audit of CalOptima departments in October 2018. The table below reflects the final audit scores for CalOptima departments. The deficiencies identified during the audit were primarily attributed to missing information in contracts and/or policies.

Department	Score
Case Management	100%
Claims	99.33%
Customer Service - Enrollment and Reconciliation	100%
Grievance & Appeals Resolution Services	100%
Network Operations – Contracting	96.05%
Network Operations – Provider Relations	95.31%
PACE	100%
Pharmacy	100%
Quality Analytics – Access and Availability	98.95%
Quality Improvement – Credentialing	87.67%
Utilization Management	100%

2. Internal Monitoring Audits: Medi-Cal [a\]

- Medi-Cal Pharmacy: Pharmacy Standard Appeals

Month	Expedited Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt	Written Response in Member's Preferred Language	Accuracy of Member Notice Content	Clinical Decision Making
August 2018	Nothing to Report	100%*	100%*	100%*	Unavailable

Note: An asterisk (*) indicates that the audit score includes CalOptima's OneCare, OneCare Connect, and Medi-Cal programs.

3. Internal Monitoring Audits: OneCare [a\]

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
August 2018	100%*	100%*	100%*

Note: An asterisk (*) indicates that the audit score includes CalOptima's OneCare, OneCare Connect, and Medi-Cal programs.

4. Internal Monitoring Audits: OneCare Connect [a\]

   - OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Resolution Timeliness	Accurate PDR Determinations	Clear and Specific PDR Resolution Language
August 2018	100%*	100%*	100%*

Note: An asterisk (*) indicates that the audit score includes CalOptima's OneCare, OneCare Connect, and Medi-Cal programs.

5. Health Network Audits: Medi-Cal

   - Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
June 2018	81%	78%	82%	77%	78%	86%	88%	80%	81%	86%	33%	72%	66%
July 2018	73%	83%	73%	72%	61%	83%	85%	82%	83%	79%	39%	70%	81%
August 2018	68%	85%	65%	50%	68%	74%	83%	79%	81%	83%	42%	53%	77%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Routine – 5 business days and Urgent – 72 hours)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

- Failure to meet timeframe for extended decision (14 calendar days)
- Failure to meet timeframe for member delay notification (5 business days)
- Failure to meet timeframe for provider delay notification (5 business days)

➢ The lower scores for clinical decision making were due to the following reasons:
- Failure to cite criteria for decision
- Failure to obtain adequate clinical information
- Failure to have appropriate professional make decision

➢ The lower letter scores were due to the following reasons:
- Failure to describe why the request did not meet criteria in lay language
- Failure to provide language assistance program (LAP) insert in approved threshold languages
- Failure to provide member with information on how to file a grievance
- Failure to provide letter in member's primary language
- Failure to provide letter with description of services in lay language
- Failure to provide peer-to-peer discussion of the decision with medical reviewer
- Failure to provide referral back to primary care provider (PCP) on denial letter
- Failure to include name and contact information for health care professional responsible for the decision to deny or modify
- Failure to provide notification to enrollee of delayed decision and anticipated final decision date
- Failure to provide notification to provider of delayed decision and anticipated final decision date

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2018	93%	90%	98%	90%
July 2018	94%	89%	96%	98%
August 2018	96%	80%	97%	86%

➢ The compliance rate for paid claims accuracy decreased from 89% in July 2018 to 80% in August 2018 due to missing documents required for processing accurate payment on claims.

➢ The compliance rate for denied claims accuracy decreased from 98% in July 2018 to 86% in August 2018 due to missing documents required for processing accurate denied claims.

6. Health Network Audits: OneCare
   - OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
June 2018	67%	100%	80%	100%	83%	100%	75%	90%
July 2018	73%	100%	89%	100%	86%	100%	75%	93%
August 2018	93%	NTR	82%	94%	90%	100%	85%	72%

- The lower score for timeliness was due to the following reason:
  - Failure to meet timeframe for provider standard notification (2 business days)

- The lower letter scores were due to the following reasons:
  - Failure to inform member of the right to file an expedited grievance if the member disagrees with the organization's decision to not expedite the determination
  - Failure to inform member of the right to resubmit a request for an expedited determination
  - Failure to provide member with information on how to file a grievance
  - Failure to provide member the reasons for delay
  - Failure to include the right to file a grievance
  - Failure to use approved CMS template
  - Failure to include CalOptima logo
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide information regarding right to standard or expedited reconsiderations
  - Failure to include description of both the standard and expedited reconsideration process
  - Failure to include member's right to submit additional information

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2018	100%	100%	93%	93%
July 2018	99%	99%	100%	93%
August 2018	100%	100%	100%	100%

- No significant trends to report.

7. Health Network Audits: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
June 2018	84%	84%	79%	81%	81%	58%	79%	80%	50%	67%	77%
July 2018	73%	67%	84%	87%	78%	58%	72%	85%	65%	58%	76%
August 2018	70%	83%	82%	73%	84%	58%	86%	76%	50%	75%	75%

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (Urgent - 72 hours; Routine - 5 days)
    - Failure to meet timeframe for provider written notification (2 business days)
    - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

  - The lower letter scores were due to the following reasons:
    - Failure to describe why the request did not meet criteria in lay language
    - Failure to provide letter in member's primary language
    - Failure to provide letter with description of services in lay language
    - Failure to provide peer-to-peer discussion of the decision with medical reviewer
    - Failure to include name and contact information for health care professional responsible for the decision to deny

- OneCare Connect Claims: Professional Claims

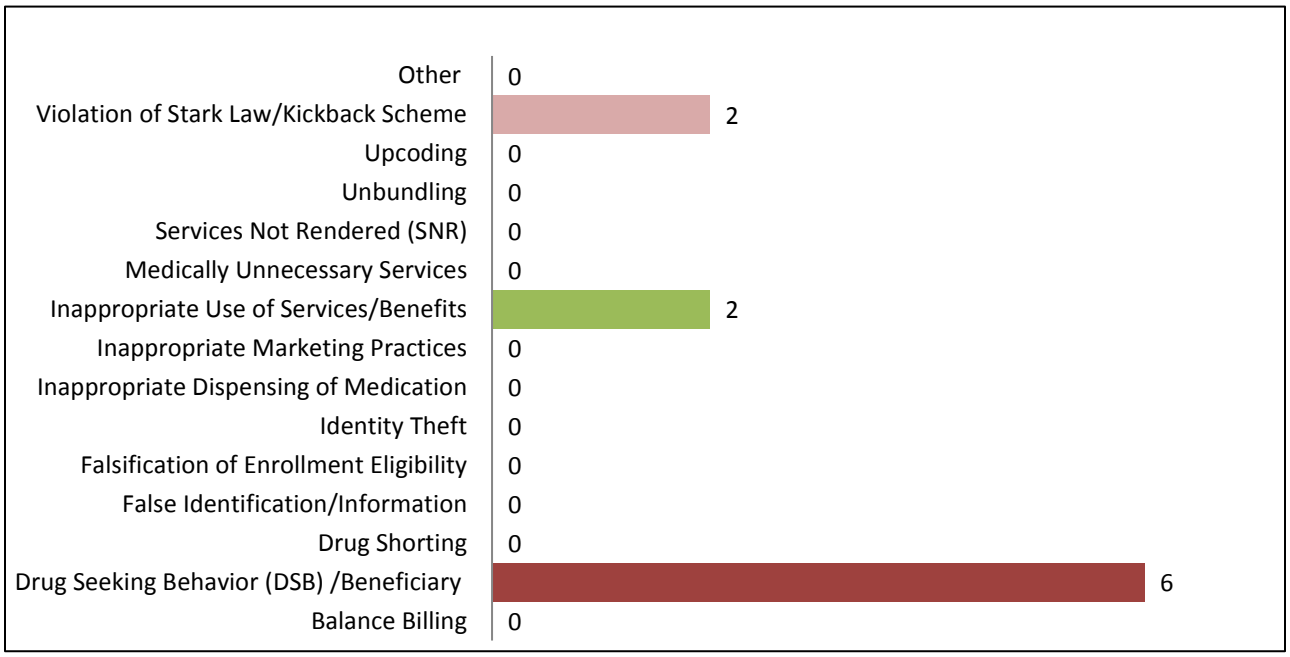
Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2018	94%	97%	99%	91%
July 2018	92%	95%	98%	98%
August 2018	81%	96%	98%	96%

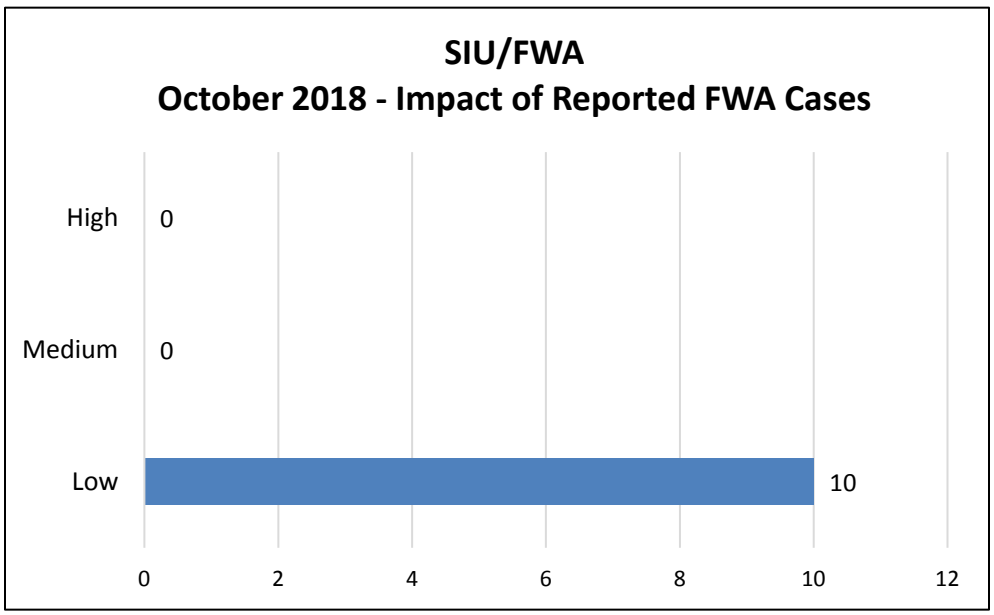
  - The compliance rate for paid claims timeliness decreased from 92% in July 2018 to 81% in August 2018 due to untimely processing of multiple claims.

- The compliance rate for denied claims accuracy decreased from 98% in July 2018 to 96% in August 2018 due to missing documents required for processing accurate denied claims.

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in October 2018)





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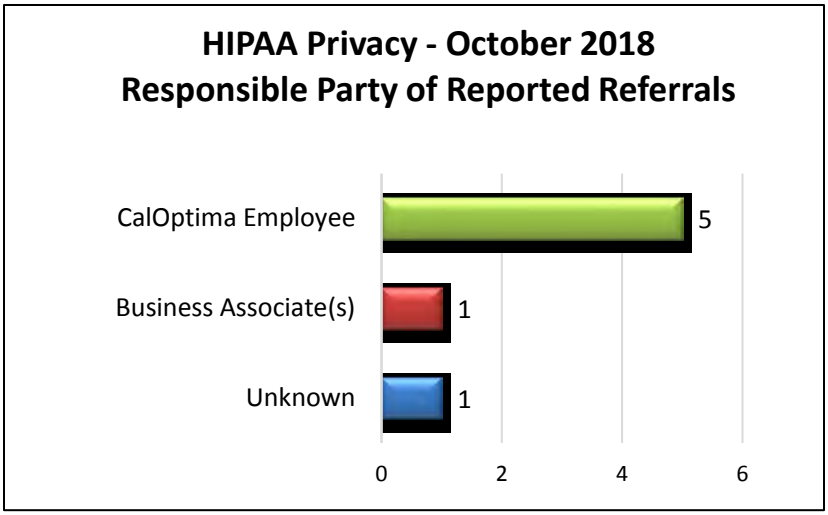
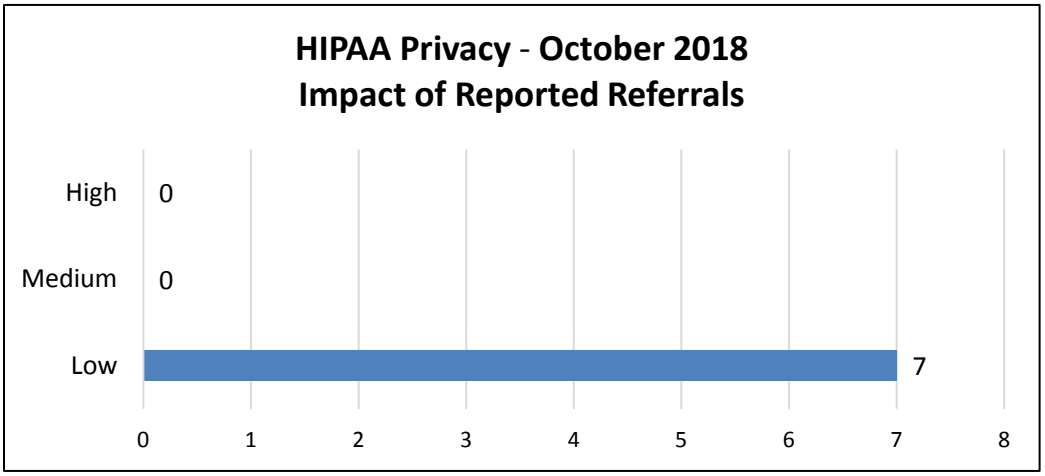
E. Privacy Update (October 2018)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	7
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**7**

Board of Directors Meeting
December 6, 2018

CalOptima Community Outreach Summary – November 2018

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Resource Fair

CalOptima's Community Relations department and the Community Alliances Forum Advisory Committee will host a Community Alliances Forum on Wednesday, December 12, 2018, from 9–11:30 a.m. at the Delhi Center in Santa Ana. The topic of the forum is "Community Engagement: Partnering with the Communities We Serve."

The featured guest speaker will be Dr. Stephany Cuevas, Doctoral Candidate in the Cultures, Communities, and Education Program at the Harvard Graduate School of Education. As a California native herself, she understands the common barriers that arise while trying to outreach to the underserved communities that we represent and serve. Her area of expertise focuses on the importance of achieving family engagement as a unit at home and in the community to yield better outcomes for students in their educational development. This same methodology can be exercised in the health care realm as we explore increased engagement strategies with the family unit for a shared partnership of responsibility in our community health outcomes.

Following the feature presentation will be the perspectives from our community partners who will share the challenges, strategies and best practices while outreaching to the various target populations they serve.

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For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During November 2018, CalOptima participated in 37 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
11/02/18	• Covered Orange County General Meeting
11/05/18	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting • Fullerton Collaborative Meeting
11/06/18	• Collaborative to Assist Motel Families Meeting • Fall Conference and Annual Meeting hosted by California Association for Adult Day Services (Registration Fee: $950 included one outreach table and registration tickets for two staff to attend the conference.)
11/08/18	• Refugee Forum of Orange County • FOCUS Collaborative Meeting • State Council on Developmental Disabilities Regional Advisory Committee Meeting • Kid Healthy Community Advisory Committee Meeting
11/12/18	• Orange County Veterans and Military Families Collaborative Meeting
11/13/18	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Meeting
11/14/18	• Anaheim Homeless Collaborative Meeting • Buena Park Collaborative Meeting
11/15/18	• Orange County Children's Partnership Committee • Orange County Women's Health Project Advisory Board Meeting
11/19/18	• Santa Ana Early Learning Initiative Meeting
11/20/18	• North Orange County Senior Collaborative General Meeting • Placentia Community Collaborative Meeting
11/21/18	• Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting

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	• La Habra Community Collaborative Meeting • La Habra Move More, Eat Healthy Campaign Meeting
11/27/18	• Orange County Senior Roundtable
11/30/18	• Orange County Strategic Plan for Aging — Health Care Subcommittee Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
11/01/18	2	• Student Health Resource Fair hosted by Santa Ana College
11/02/18	1	• Resource Fair and Flu Shot Clinic hosted by the City of Tustin (Registration Fee: $25 included one outreach table)
11/03/18	3	• Annual Alzheimer's Latino Conference hosted by Alzheimer's Orange County (Sponsorship Fee: $2,500 included opportunity to give a welcome presentation, acknowledgement in press releases and advertisement for one month prior to conference, logo prominently place around conference and on the agenda, in looping video acknowledgement, information in goody bags, an exhibit table, lunch for two staff, and a certificate of recognition.)
	1	• Health and Wellness Fair hosted by Nhan Hoa Comprehensive Health Center
	2	• Health Fair and Flu Shot Clinic hosted by City of Aliso Viejo
	5	• Noche de Altares (Night of Altars) hosted by El Centro Cultural de Mexico (Sponsorship Fee: $3,500 included a booth space to have a resource table during the event, event poster recognition, on-stage verbal promotion throughout event, program recognition and agency listed in event website.)
	1	• Senior Week Health and Wellness Fair hosted by Institute for Healthcare Advancement (Registration Fee: $75 included one outreach table.)
11/08/18	2	• Annual Resource Fair hosted by CHOC Children's Hospital
	1	• Senior PEP Talk and Resource Fair hosted by Orange County Aging Services Collaborative
11/10/18	2	• Veterans Resource Fair hosted by the Office of Assemblyman Brough and Senator Bates
11/16/18	2	• Health Fair hosted by Ponderosa Family Resource Center

CalOptima organized or convened the following 14 community stakeholder events, meetings and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
11/01/18	• CalOptima New Member Orientation (Vietnamese)

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11/02/18	• County Community Service Center Health Seminar — Topic: Medi-Cal Recovery Law (Vietnamese)
11/07/18	• County Community Service Center Health Seminar — Topic: Cold/Flu and Shingles (Vietnamese)
11/09/18	• County Community Service Center Health Seminar — Topic: IrisOC Focus Group (Vietnamese)
11/13/18	• CalOptima Community Presentation for Boat People SOS-CA — Topic: Transportation Benefits • Mobile Mammogram Event at Miraloma Park Family Resource Center in Anaheim • CalOptima New Member Orientation (English and Spanish)
11/14/18	• County Community Service Center Health Seminar — Topic: Denti-Cal: Understanding Medi-Cal Covered Dental Benefits • CalOptima Community Presentation for Placentia Head Start — Topic: Introduction to CalOptima • CalOptima New Member Orientation (Farsi and Korean)
11/15/18	• CalOptima Health Education Event — The Great American Smokeout Event
11/17/18	• OneCare Connect Member Recognition Event at Delhi Community Center
11/29/18	• CalOptima New Member Orientation (Chinese, Arabic and Vietnamese)

CalOptima provided zero endorsements for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

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CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

December

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Monday, 12/3 1-4pm	++OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 12/4 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 12/5 9-10:30am	++OC Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 12/5 10am-12pm	++Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Family Justice Center 150 W. Vermont Anaheim
Wednesday, 12/5 10:30am-12pm	++OC Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Thursday 12/6 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange

+ Exhibitor/Attendee
++ Meeting Attendee

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Friday, 12/7 10-11am	++Help Me Grow Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Monday, 12/10 1-2:30pm	+OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 12/10 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 12/11 9-10:30am	++Orange County Strategic Plan for Aging-Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 12/12 9-11:30am	*Community Alliances Forum	Community Presentation *Registration requested*	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Wednesday, 12/12 6:30-8:30pm	*CalOptima CME Workshop	Presentation for Physicians and Licensed Health Care Professionals *Registration required.*	N/A	DoubleTree Hotel 100 The City Dr. Orange
Thursday, 12/13 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Thursday, 12/13 12:30-1:30pm	++Kid Health Advisory Committee Mtg	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC 1901 E. Fourth St. Santa Ana
Friday, 12/14 9:30-11am	++Senior Citizen Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Tuesday, 12/18 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia

Wednesday, 12/19 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 12/19 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 12/19 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Thursday, 12/20 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 12/20 2:30-4:30pm	++Surf City Senior Providers Network and Lunch	Steering Committee Meeting: Open to Collaborative Members	N/A	Senior Center Central Park 18041 Goldenwest St. Huntington Beach
Thursday, 12/20 2:30-4:30pm	++OC Women's Health Project Advisory Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Thursday, 12/27 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 12/27 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana