NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, SEPTEMBER 3, 2020
2:00 P.M.

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

BOARD OF DIRECTORS

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

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

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

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

The Board Meeting Agenda and supporting materials are available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima website at www.caloptima.org.

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

1) **Listen to the live audio at +1 (914) 614-3221 Access Code: 737-564-539 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/9094654818707774990**
3) **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. Medi-Cal Expansion Rate Adjustment
   b. Withdrawal of Proposed Long-Term Care at Home Benefit
   c. Medi-Cal 2020 Waiver Extension Request
   d. COVID-19 Response
   e. Medi-Cal Rx Transition
   f. Annual Network Certification
   g. Proposition 56 Directed Payment Programs
   h. Whole-Child Model Population Correction

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

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the August 6, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the June 11, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee and the June 11, 2020 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

REPORT ITEMS
3. Consider Election of Officers of the CalOptima Board of Directors

4. Consider Authorizing Contract(s)/Contract Amendment(s) with Vendor(s) and Authorizing Unbudgeted Funds to Provide Communication Devices, and Ongoing Service Plans and Related Services to Participants in the CalOptima Program of All-Inclusive Care for the Elderly

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

6. Consider Approval of Proposed Revisions to CalOptima's Customer Service Policies and Procedures

7. Consider Approving Modifications to CalOptima's Medi-Cal and OneCare Connect Policy GG.1822: Process for Transitioning CalOptima Members Between Levels of Care

8. Consider Authorizing Actions Related to Payments to and Contract Terms with the Children's Hospital of Orange County Physician-Hospital Consortium Health Network

9. Consider Authorizing Renewal of the Program of All-Inclusive Care for the Elderly Primary Care Provider (PCP) Incentive Program and Related Changes to PCP Contracts

10. Consider Actions Related to Intergovernmental Transfer (IGT) 5 Community Grant Contract(s) in Response to COVID-19

11. Consider Appointments of Member Advisory Committee and Provider Advisory Committee Chair and Vice Chair

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

13. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event

ADVISORY COMMITTEE UPDATES

14. Member Advisory Committee Update

15. Provider Advisory Committee Update

INFORMATION ITEMS

16. COVID-19 Update

17. Medi-Cal Pharmacy Carve Out

18. Intergovernmental Transfer Overview

19. Strategic Plan Update

20. Chief Executive Officer Recruitment Update

21. July 2020 Financial Summary

22. Compliance Report

23. Federal and State Legislative Advocates Reports

24. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 Pursuant to Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on September 3, 2020 2:00 PM PDT at: https://attendee.gotowebinar.com/register/9094654818707774990
2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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

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   TO USE YOUR TELEPHONE:

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   Access Code: 737-564-539

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	August 26, 2020
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Interim CEO
SUBJECT:	CEO Report — September 3, 2020, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

CalOptima Responding to Possible Medi-Cal Expansion (MCE) Rate Adjustment
At the August Board meeting, I shared that the Department of Health Care Services (DHCS) and its actuarial consultant, Mercer, contacted CalOptima at the end of July to discuss the MCE rate for the upcoming calendar year. DHCS presented an initial analysis showing that the rates CalOptima pays providers for the MCE population are substantially higher than the costs reported by other County Organized Health Systems. Therefore, DHCS is considering implementing a significant reduction, effective January 1, 2021. CalOptima has formally requested a glidepath on this rate reduction and is seeking additional information before the draft rate release by DHCS. As of August 26, CalOptima had not received details about the final cut in terms of a percentage or dollars. CalOptima had already built in a total 10% capitation rate reduction for health networks for MCE members in our FY 2020–21 budget. Staff is currently evaluating the potential budget impact in addition to what was already included in this year's budget. If the final rate cut is substantially higher than what is anticipated in the current budget, we are considering options to mitigate additional financial impact to health networks and providers and will bring the options to the Board later this year. CalOptima has been communicating about this issue as transparently as possible, including at the August 11 Health Network CEO Meeting and August 20 Health Network Forum.

State Ends Pursuit of New Long-Term Care at Home Medi-Cal Benefit
On August 24, DHCS announced that it will not pursue the Long-Term Care at Home Medi-Cal benefit that was originally proposed in May. The intent of the benefit was to reduce the nursing home population amid the pandemic by offering a coordinated and bundled set of medical and home- and community-based services. However, Gov. Newsom's administration and the Legislature were unable to agree on a process to develop and implement the benefit at this time. In making the announcement, DHCS acknowledged and thanked Medi-Cal plans for their work and collaboration over the past few months.

Medi-Cal 2020 Waiver Extension Request Nearing Submission
DHCS is pursuing CMS approval of a 12-month extension of the federal waiver under which the majority of Medi-Cal operates. California's Section 1115 Medicaid waiver, known as Medi-Cal 2020, is effective through December 31, 2020. DHCS' extension request was released July 22, and the 30-day comment period closed August 21. After reviewing stakeholder comments and updating the extension request accordingly, the state plans to submit it to CMS by September 15.

Back to Agenda

Orange County Removed From COVID-19 Watchlist, CalOptima Response Continues
On August 23, Orange County was removed from the California watchlist based on improvement in certain COVID-19 measures. However, CalOptima continues to address to the needs of members and providers still grappling with the ongoing pandemic. From our first case until August 24, CalOptima has reported 2,790 positive cases, 1,463 hospitalizations and 212 deaths. Below are updates in several areas of pandemic response.

- *Electronic Resources:* CalOptima regularly updates our COVID-19 web pages for members, providers and the community to ensure availability of the latest information. Further, each Wednesday, CalOptima distributes an email newsletter containing a wide variety of resources to more than 2,500 individuals from community-based organizations. Past issues are available at the community page link above.
- *New All-Plan Letter (APL):* On August 19, DHCS released an APL with updated emergency guidance for Medi-Cal managed care plans in response to COVID-19. The changes affect several areas, including COVID-19 testing requirements and reimbursement, suicide prevention practices for providers, long-term care reimbursement, encounter data collection and submission, and pharmacy services. CalOptima's Regulatory Affairs and Compliance team analyzes APLs and ensures that the affected departments are aware of the changes.
- *Federal Waiver Approval:* On August 19, the Centers for Medicare & Medicaid Services (CMS) approved DHCS' request for program flexibility related to provision of telehealth services by clinics, retroactive to March 1 and for the duration of the public health emergency. On August 20, CMS also issued additional blanket regulatory waivers that affect providers nationwide. The full list of waivers is on CMS' website here.
- *Infection Prevention:* UC Irvine, the Orange County Health Care Agency and CalOptima jointly launched the Orange County Nursing Home COVID-19 Infection Prevention Program on June 1, and adoption has been strong. The program offers either intensive, in-person training or access to an online toolkit. Intensive intervention is available for a maximum of 12 nursing homes, and 11 have signed on. This group is receiving weekly in-person visits with leaders and training sessions with staff to review toolkit materials and video feedback. Separately, more than 70 nursing home leaders attended a CalOptima-hosted webinar on July 9 to debut the online toolkit (www.ucihealth.org/stopcovid), which is ahead of schedule. Seven of the 12 sections are complete, with 30+ documents and 20 videos. The impact of the coaching has been immediate, as participating facilities report staff enthusiasm and adherence to proper infection protocols because personal safety, in addition to patient safety, is emphasized. The goal is to hardwire infection prevention techniques in staff, which will be invaluable in the expected viral resurgence this fall.
- *Mental Health:* CalOptima's Communications department routinely works to elevate the agency's profile as a top source of health information in the community. This month, Parenting OC Magazine ran an "Ask the Experts" piece on kids' mental health during COVID-19, with a byline from Dr. Edwin Poon, director of behavioral health integration.

Preparation Continues for January 2021 Transition to Medi-Cal Rx
On August 5, DHCS held another webinar to update managed care plans regarding the upcoming transition to Medi-Cal Rx, the state-managed pharmacy benefit program operated by Magellan. Officials stated that two All Plan Letters to clarify the roles and responsibilities of managed care plans are nearing release. Magellan completed a first round of data exchange testing with managed care plans and started a second cycle of test files on August 6. Regarding communications, member notices are in final review, and the 90- and 60-day notices from the

state will be identical. CalOptima will send a customized 30-day notice to members. The state is currently working on a provider bulletin to provide guidance on how to access the portal and obtain training. Staff will present information about the Medi-Cal Rx transition at the September 3 Board meeting.

Annual Network Certification Project Underway in Preparation for July 2021 Start

Under new DHCS rules, all managed care plans are required to file Annual Network Certifications to ensure each of their delegated health networks meets specific requirements in the following areas:

- Maintaining the required number and mix of primary and specialty providers
- Meeting all time and distance standards for providers throughout their service area
- Complying with service availability, physical accessibility, out-of-network access, timely access, continuity of care and 24/7 language assistance requirements

In collaboration with our networks, CalOptima began this major effort earlier this year by conducting analysis, identifying barriers and opportunities for health networks, and examining alternative strategies for addressing potential deficiencies. These alternatives may include defined service areas for health networks that do not meet time and distance standards. CalOptima recently received DHCS approval of our plan to implement the new requirements for Annual Network Certification. The certifications must be submitted to DHCS by March 2021 and implemented by July 1, 2021. CalOptima is working to ensure that all health networks, including CalOptima Community Network, meet state standards.

New Proposition 56 Directed Payment Programs Support Family Planning, Value-Based Payment

The Legislature has appropriated Prop 56 tax dollars to DHCS directed payment programs through FY 2021, including two recently released programs impacting family planning services and value-based payment. CalOptima and our health networks will make these add-on payments according to regulatory guidance for dates of service on or after July 1, 2019. Health networks will be reimbursed for the add-on payments according to CalOptima policy, and the impacted policies will be updated and presented to the Board for approval. One program aims to improve quality of care by ensuring that providers receive enhanced payment for delivery of several types of family planning services. The other program offers value-based payments to eligible providers who meet specific performance measures in the areas of prenatal/postpartum care, early childhood care, chronic disease management and behavioral health integration.

Decrease in Whole-Child Model (WCM) Population Noted and Being Addressed

For my August CEO Report, staff inadvertently provided incorrect data regarding WCM enrollment due to an ad hoc reporting logic error. See below for corrected data that is consistent with our reporting to DHCS:

Report Date	Incorrectly Reported	Corrected Reporting
July 1, 2019	12,317	11,874
July 1, 2020	14,652	10,280

In the future, all ad hoc reports will have a second point of validation from a separate business area familiar with the data set. While the overall number of eligible California Children's Services (CCS) members decreased this past year, CalOptima and the Orange County CCS program are working closely to streamline the eligibility process and ensure that members are

appropriately referred for CCS eligibility determination. Since March 2020, coinciding with the COVID-19 public health emergency, CalOptima has observed a decrease in new CCS eligibility. The average number of new CCS-eligible members from July 1, 2019–February 29, 2020, was 238 per month, compared with 140 per month from March 1, 2020, to present. We will continue to monitor CCS eligibility trends and work with the county to provide access to needed health care services for members regardless of CCS-eligibility status.

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

August 6, 2020

A Regular Meeting of the CalOptima Board of Directors was held on August 6, 2020, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Interim Chief Executive Officer, Richard Sanchez called the meeting to order at 2:07 p.m. and led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra; Jackie Brodsky; Clayton Chau (non-voting); Clayton Corwin; Supervisor Andrew Do; Mary Giammona, M.D. (at 2:15 p.m.); Victor Jordan; Scott Schoeffel; Supervisor Michelle Steel; Trieu Tran, M.D.
(All members at teleconference locations except Supervisor Do and Scott Schoeffel)

Members Absent: None

Others Present: Richard Sanchez, Interim Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; David Ramirez, M.D. Chief Medical Officer; Sharon Dwiers, Clerk of the Board

Mr. Sanchez welcomed Isabel Becerra, Jackie Brodsky, Clayton Corwin, Dr. Mary Giammona, Victor Jordan, and Dr. Trieu Tran, CalOptima's six newly appointed Board Members to their first CalOptima Board meeting. He asked the Clerk to administer the ceremonial oath of office.

Mr. Sanchez also mentioned that the CalOptima Board of Directors typically has its annual organizational meeting in June, at which it elects its Chair and Vice-Chair for the coming fiscal year. However, with many former Board Members completing their service at the June meeting, it made more sense to hold the election after the new Board members were seated, and this item will be included on the September agenda.

Following a request for volunteers, Supervisor Do agreed to serve as Acting Chair for today's meeting to maintain continuity and Isabel Becerra agreed to serve as Acting Vice-Chair.

PUBLIC COMMENTS

1. Kerri Ruppert Schiller, CHOC – Oral re: Agenda Item 12, Consider Ratification of Amendment to Health Network Contract with Children's Hospital of Orange County and Authorization of Related Funding

Back to Agenda

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Mr. Sanchez highlighted several items from his report, including new information received from the California Department of Health Care Services (DHCS) regarding capitation rates. Late last week, CalOptima was invited to take part in a call with DHCS rate development staff and Mercer, DHCS's actuarial consultant. While more information will be provided as it becomes available, the focus of the call was that the state's analysis shows that the rates CalOptima is paying providers for the Medi-Cal Expansion population are significantly higher than those paid by other County Organized Health System plans. As such, the DHCS is looking at implementing significant reductions to the rates it pays CalOptima beginning as early as January 1, 2021.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the June 4, 2020 Regular Meeting of the CalOptima Board of Directors

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

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

REPORTS

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

Silver Ho, Executive Director, Compliance introduced the item and provided background on CalOptima's primary agreement with DHCS and the relevant amendments.

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute an amendment to the Primary Agreement between DHCS and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule). (Motion carried 9-0-0)***

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

Ms. Ho introduced this item and provided background on the contract amendment.

Back to Agenda

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors ratified Revised Amendment 04 to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS), in order to continue operation of the OneCare program. (Motion carried 9-0-0)***

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

Tracy Hitzeman, R.N. Executive Director, Clinical Operations introduced the item.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors approved CalOptima Policy and Procedure, GG.1352: Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21 consistent with state requirements. (Motion carried 9-0-0)***

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

Ms. Hitzeman introduced the item and provided background information.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to modify the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows: 1.) Policy GG.1503 CalOptima Hospice Coverage, Notification and Validation Requirements; and 2.) Policy GG.1808: Plan of Care, Long Term Care. (Motion carried 9-0-0)***

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

Emily Fonda, M.D., Deputy Chief Medical Officer, introduced the item provided background on each of the impacted policies.

After considerable discussion, the Board requested additional information on the pharmacy carve-out and the impact it will have on CalOptima's members. Also, the Board requested detail on the number of members affected, possible delays in medication, and how the pharmacy carve-out will affect finances. Mr. Sanchez responded that CalOptima would add the pharmacy carve-out to the September agenda, and include the details requested by the Board for discussion.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors approved modifications to the following existing policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows: 1.) MA.6106 Medication Therapy Management [OneCare, OneCare Connect]; 2.) GG.1406 Pharmacy Network: Credentialing and Access [Medi-Cal, OneCare, OneCare Connect, PACE]; 3.) GG.1409 Drug Formulary Development and Management [Medi-Cal]; 4.) GG.1410 Appeal Process for Pharmacy Authorizations [Medi-Cal]; and 5.)***

Back to Agenda

GG.1423 Medication Quality Assurance Program [Medi-Cal] (Motion carried 9-0-0)

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

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 Steel, seconded and carried, the Board of Directors ratified the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020. (Motion carried 8-0-0; Director Schoeffel absent)***

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

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

Michelle Laughlin, Executive Director, Network Operations, introduced the item.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors 1.) Authorized currently participating Physician-Hospital Consortium (PHC) Health Networks to change their contract risk model for the Medi-Cal (MC) line of business to a Health Maintenance Organization (HMO) model, subject to successfully completing CalOptima's readiness assessment and obtaining Department of Managed Health Care (DMHC) licensure; and, 2.) Authorized the termination of the Medi-Cal PHC health network current Physician and Hospital contracts to transition the capitated membership to the HMO health network model; and, 3.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute contracts and/or contract amendments necessary to implement the new HMO model for existing PHC Health Networks that elect to participate in CalOptima's Medi-Cal program under the HMO model. (Motion carried 7-0-1; Supervisor Do abstained; Director Schoeffel absent)***

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

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

Ms. Laughlin introduced this item, noting that it is related to the pharmacy carve out and providing pharmacy data on CalOptima's members to Magellan, the state's pharmacy benefit manager.

Action: ***On motion of Director Giammona, seconded and carried, the Board of***

Directors ratified actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California. (Motion carried 8-0-0; Director Schoeffel absent)

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

David Ramirez, M.D., Chief Medical Officer, introduced this item.

Supervisor Steel thanked staff for all of their work to ensure that our seniors are getting the care they need during the COVID-19 pandemic and stay-at-home orders.

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors ratified the following temporary operational changes made by CalOptima PACE management in response to the Coronavirus (COVID-19) pandemic: 1.) Provision of skilled home health services by qualified CalOptima PACE employees; and 2.) Updated job descriptions for qualified employees to provide home health services. (Motion carried 9-0-0)***

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

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

Mr. Sanchez introduced this item and provided background on the rebasing effort, noting that Children's Hospital of Orange County (CHOC) is unique as CalOptima's single pediatric only health network. He also mentioned that CalOptima and CHOC staff have been working together during the recommended two-month extension period, which is intended to allow CHOC more time to validate its data and submit any additional analysis to CalOptima if it believes there is a basis for it to receive different rates than those approved by the Board in June that factor in the results of rebasing. Staff will review CHOC's analysis and return to the Board with further recommendations as appropriate.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors ratified amendment to the Children's Hospital of Orange County's Health Network Hospital Contract (Hospital Contract Amendment) incorporating a 60-day review period of the rebased capitation rates (Review Period) and the continuation of pre-amendment base rates through the use of supplemental payments for such Review Period; 2.) Authorized unbudgeted expenditures of up to $2.4 million from existing reserves for the Hospital Contract Amendment Review Period supplemental payments; and 3.) Made a finding that such Review Period supplemental expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 8-0-0; Director Schoeffel absent)***

Back to Agenda

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors, 1.) Reappointed the following individuals to serve two-year terms on the OneCare Connect Member Advisory Committee, effective July 1, 2020 to June 30, 2022; a.) Gio Corzo as the Community Based Adult Services (CBAS) Representative for a term ending June 30, 2022; b.) Keiko Gamez as the Member/Family Member Representative for a term ending June 30, 2022; c.) Donald Stukes as the Member Advocate Representative for term ending June 30, 2022; and d.) Patty Mouton as the Representing Seniors Representative for a term ending June 30, 2022; and 2.) Appointed Eleni Hailemariam, M.D. as the non-voting Orange County Health Care Agency (OCHCA) Representative. (Motion carried 9-0-0)***

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors, 1.) Reappointed the following individuals to serve two-year terms on the Whole-Child Family Advisory Committee, effective upon Board approval; a.) Cathleen Collins as an Authorized Family Member Representative for a term ending June 30, 2022; and b.) Kristen Rogers as an Authorized Family Member Representative for a term ending June 30, 2022; and 2.) Appointed the following individual to serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board approval: a.) Maura Byron as a Community Based Organization Representative for a term ending June 30, 2022. (Motion carried 9-0-0)***

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors appointed the following agency-selected voting liaison representative to the Member Advisory Committee effective upon Board Approval: a.) Steven Thronson, Deputy Agency Director, as the Orange County Health Care Agency Representative. (Motion carried 9-0-0)***

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1.) Adopted Resolution Number 20-0806-01, to extend the Chair and Vice Chair term lengths from one to two years for the following CalOptima Board***

of Directors' Advisory Committees: a.) Member Advisory Committee; b.) OneCare Connect Member Advisory Committee; c.) Provider Advisory Committee; and d.) Whole-Child Model Family Advisory Committee; and 2.) Authorized updates to the following Policies and Procedures in accordance with CalOptima's regular review process to reflect the recommended changes in duration of Chair and Vice Chair term lengths: a.) AA.1219a: Member Advisory Committee; b.) CMC.1007: OneCare Connect Member Advisory Committee; c.) AA.1219b: Provider Advisory Committee; and d.) AA.1271: Whole-Child Model Family Advisory Committee (Motion carried 9-0-0)

ADVISORY COMMITTEE UPDATES

17. Member Advisory Committee Update
Christine Tolbert, Member Advisory Committee (MAC) Chair, welcomed new CalOptima Board Members and provided an update on recent MAC activities.

18. OneCare Connect Member Advisory Committee Update
Patty Mouton, OneCare Connect Member Advisory Committee (OCC MAC) Chair, welcomed new CalOptima Board Members and provided an update on OCC MAC activities.

19. Whole Child Model Family Advisory Committee Update
Maura Byron, Whole Child Model Family Advisory Committee (WCM FAC) Chair, welcomed new CalOptima Board Members and provided an update on WCM FAC activities, noting that the one-year anniversary of the implementation of the Whole Child Model was recently passed.

20. Provider Advisory Committee Update
John Nishimoto, Provider Advisory Committee (PAC) Chair, welcomed new CalOptima Board Members and provided an update on recent PAC activities.

INFORMATION ITEMS

21. Real Estate Update
Nancy Huang, Chief Financial Officer, introduced this item, noting that the Board approved a request for proposal (RFP) process that resulted in the selection of Newmark Knight Frank (NKF) as CalOptima's real estate consultant. Ms. Huang added that, with the recent changes in the real estate market and in CalOptima's internal business priorities, she has asked consultants from NKF, Justin Hodgdon, Project Manager, and David Kluth, Account Manager, to provide the Board with an update.

Mr. Hodgdon and Mr. Kluth provided an overview of NKF and provided an update on their activities related to real estate and the changes necessitated by the pandemic. NKF is continuing to monitor the real estate market and is in negotiations with the landlord of CalOptima's Program of All-Inclusive Care for the Elderly (PACE) facility. The consultants noted that the PACE building is leased, and the lease is set to expire at the end of next year, so they are looking at options. NKF is also working with CalOptima staff on the Development Rights Agreement between the City of Orange and CalOptima. The agreement with the city is set to expire in October 2020, and staff has submitted an application to

extend the current agreement. Any further recommendations will be brought back to the Board for approval.

The following Information Items were received as presented:

22. May and June 2020 Financial Summaries
23. Compliance Report
24. Federal and State Legislative Advocates Reports
25. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Acting Chair Do noted that the next meeting is scheduled for Thursday, September 3, 2020, at 2:00 p.m., and asked that staff survey Board members on their day and time preferences for the monthly Board meetings.

Mr. Sanchez also mentioned that after the election of the CalOptima Board Chair and Vice Chair at the September meeting, the Chair would need to appoint members of the Board to serve on the Finance and Audit Committee (FAC) and the Quality Assurance Committee (QAC). Both the FAC and the QAC currently have three seats, and both Committees have meetings scheduled in September.

Acting Chair Do asked members of the Board to communicate their interest in serving on either of the Committees.

ADJOURNMENT

Hearing no further business, Acting Chair Do adjourned the meeting at 4:33 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 3, 2020

Back to Agenda

MINUTES

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

June 11, 2020

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, June 11, 2020 via teleconference using Goto Webinar technology at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:02 a.m. and Vice Chair Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

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

Members Absent: None

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

Chair Nishimoto welcomed Jennifer Birdsall, Ph.D. and Peter Korchin to the PAC as the new Allied Health Representatives who will be fulfilling existing terms on the PAC. Dr. Birdsall and Mr. Korchin provided brief backgrounds on themselves. Dr. Nishimoto also noted that all the seats on the PAC were now full.

MINUTES

Approve the Minutes of the May 14, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Batra, seconded and carried, the Committee approved the minutes of the May 14, 2020 regular meeting. (Motion carried 15-0-0)***

Back to Agenda

PUBLIC COMMENTS

There were no public comments.

REPORTS

Consider Approval of the FY 2019-2020 Provider Advisory Committee Accomplishments

Chair Nishimoto reviewed the FY 2019-20 PAC Accomplishments and noted that these accomplishments would be presented as an informational item to the CalOptima Board of Directors.

Action: ***On motion of Member Tran, seconded and carried, the Committee approved the FY 2019-2020 PAC Accomplishments (Motion carried 15-0-0)***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer (CEO), provided an update on CalOptima's Fiscal Year 2020-21 Budget which was approved by the CalOptima Board of Directors at its June 4, 2020 meeting. Mr. Sanchez also discussed Governor Newsom's May Revision to his proposed budget for the state for FY 2020-21 and noted that TC Roady would provide more in-depth information. He also noted that the four-year terms for the current members of CalOptima's Board of Directors would be expiring, and that at the Board of Supervisors' June 2, 2020 meeting, the new CalOptima Board members were appointed.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, discussed the provider and health network contract renewals which will take effect July 1, 2020. Ms. Khamseh also noted that CalOptima is continuing to encourage staff to maintain social distancing and to wear face masks.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, provided an update on Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid (CMS) regulatory changes. He noted that DHCS announced that California Advancing and Innovating Medi-Cal (CalAIM) will be delayed and has requested that CMS extend the California Medicaid 1115 Waiver.

Chief Financial Officer Update

Nancy Huang, Chief Financial Officer (CFO), presented a quarterly financial update to the PAC. In addition, Ms. Huang reviewed CalOptima's FY 2020-21 budget.

INFORMATION ITEMS

Coronavirus (COVID-19) Update

Dr. Ramirez presented an update on the Coronavirus (COVID-19) pandemic. Dr. Ramirez reviewed Governor Newsom's COVID-19 Resilience Roadmap and the Orange County Health Officer's social distancing, self-isolation, and self-quarantine orders. Dr. Ramirez also updated the PAC

Back to Agenda

members on CalOptima's next steps regarding social distancing precautions and the current teleworking status.

CalOptima Members Experiencing Homelessness

Mary Botts, Enterprise Analytics Manager, presented on CalOptima members experiencing homelessness. Ms. Botts provided a high-level overview on the CalOptima Homeless Population Clinical Report Card, Medi-Cal Homeless Enrollment Trends, and the Homeless Utilization Trends. Ms. Botts noted that CalOptima's Board of Directors' approved the expansion of the Homeless Clinical Access Program (HCAP) incentives which includes the Clinical Field Teams (CFT) services and telehealth visits.

Federal and State Legislative Update

TC Roady, Director, Regulatory Affairs, provided an update on Governor Newsom's May Revise Budget and the expected impact to CalOptima's Medi-Cal members. He noted that the budget is scheduled for a vote by the Legislature on June 15, 2020. Mr. Roady also mentioned that the Community Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP) Programs, which were originally slated to be cut in the May Revise, were added back into the State budget.

PAC Member Updates

Chair Nishimoto announced that this meeting would be the last one for several PAC Members whose terms were expiring. He thanked Craig Myers, Pat Patton, and Dr. Jacob Sweidan for their service on the PAC. Chair Nishimoto also noted that newly appointed PAC Members, Christy Ward, Alpesh Amin M.D. and Alexander Rossel, along with current PAC Member Jena Jensen (who applied for the Hospital seat) had been appointed by the CalOptima Board at its June 4, 2020 meeting, and that their terms will begin on July 1, 2020. Chair Nishimoto reminded the members that a new Chair and Vice Chair will be chosen at the August 13, 2020 meeting, and that PAC members interested in applying should send an email to Cheryl Simmons to notify her of their interest.

ADJOURNMENT

Chair Nishimoto announced that the next PAC meeting is scheduled for Thursday, August 13, 2020 at 8:00 a.m.

Hearing no further business, Chair Nishimoto adjourned the meeting at 10:04 a.m.

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

Approved: August 13, 2020

Back to Agenda

MINUTES

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

June 11, 2020

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on June 11, 2020, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Tolbert called the meeting to order at 2:33 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Maura Byron; Diana Cruz-Toro; Sandra Finestone; Connie Gonzalez; Patty Mouton; Sally Molnar; Jaime Munoz; Sr. Mary Therese Sweeney; Mallory Vega.

Members Absent: Hai Hoang

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Deputy Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Belinda Abeyta, Executive Director, Operations; Betsy Ha, Executive Director, Quality & Population Health Management; TC Roady, Director, Regulatory Affairs; Mary Botts, Manager, Enterprise Analytics; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant,

MINUTES

Approve the Minutes of the May 14, 2020 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

PUBLIC COMMENT
There were no public comments.

REPORTS

Consider Recommendation of Agency Appointed Representative from the Orange County Health Care Agency (OCHCA)
Chair Tolbert reviewed the candidate appointed by the OCHCA and reminded the members that in 2019, Member Donna Grubaugh had notified CalOptima of her resignation from the MAC due to her retirement from the OCHCA. The OCHCA has named Steve Thronson, Deputy Director as the representative for the OCHCA's standing seat on MAC.

Back to Agenda

Action: ***On motion of Member Pamela Pimentel, seconded and carried, the MAC approved the recommendation to appoint Steve Thronson as the OCHCA representative (10-0-0, Member Hoang absent)***

Consider Approval of the Member Advisory Committee FY 2019-2020 Accomplishments
Chair Tolbert reviewed the FY 2019-20 MAC Accomplishments and noted that they would be part of the August 6, 2020 Board book.

Action: ***On motion of Member Jaime Munoz, seconded and carried, the Committee approved the MAC FY 2019-2020 Accomplishments (10-0-0, Member Hoang absent)***

Chair Tolbert rearranged the agenda to hear agenda item VII.B Children's Hospital of Orange County (CHOC) Thompson Autism Center Presentation.

CHOC Children's Thompson Autism Center Presentation
Jonathan T. Megarian, M.D., Medical Director of the Thompson Autism Center at Children's Hospital of Orange County (CHOC) provided a comprehensive presentation on CHOC's new Thompson Autism Center. Dr. Megerian discussed the benefits and services that are being offered at the center which opened in January 2020. Dr. Megerian also provided an overview of the challenging behavior unit, the assessment clinic, and the co-occurring clinic which is available to children and their families.

Chair Tolbert returned to the CEO and Management Reports portion of the agenda after the conclusion of Dr. Megarian's presentation.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer (COO) Update
Ladan Khamseh, Chief Operating Officer, provided a verbal update on CalOptima's COVID-19 outreach response to members regarding telehealth services and social distancing reminders. Ms. Khamseh also noted that CalOptima's health networks and provider contract amendments had been sent out in May and were awaiting the providers to return the signed amendments. She also notified the members that the base rate for skilled nursing facilities had been increased. Ms. Khamseh also discussed how a Request for Proposal (RFP) is being utilized to find a vendor to assist with updating the Provider Directory.

Chief Medical Officer (CMO) Update
David Ramirez, M.D., Chief Medical Officer, provided a verbal update on the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid (CMS) regulatory changes. Dr. Ramirez also noted that DHCS announced that CalAIM would be delayed and CMS had requested that the California Medicaid 1115 Waiver be extended for another year. Dr. Ramirez also mentioned that the Health Homes Program (HHP) Phase 2 for Behavioral Health and Substance Abuse will go into effect July 1, 2020.

Back to Agenda

INFORMATION ITEMS

MAC Member Updates

Chair Tolbert announced that at the June 4, 2020 Board Meeting the following individuals were reappointed to the MAC: Pamela Pimentel, Sr. Mary Therese Sweeney, Sally Molnar, Christine Tolbert. The Board also approved the new appointments of Maura Byron as the Family Support Representative, Melisa Nicholson as the Foster Children Representative, and Patty Mouton as the Long-Term Services and Supports Representative. She noted that recruitment would continue for the Consumer and Medi-Cal Beneficiaries Representatives.

Chair Tolbert on behalf of the MAC said farewell to Jaime Munoz, Foster Children Representative and thanked him for his service on the committee and also reminded the members that a new Chair and Vice Chair will be chosen at the August 13, 2020 meeting, and that MAC members interested in applying should send an email to Cheryl Simmons to notify her of their interest.

Coronavirus COVID-19 Update

Emily Fonda, M.D., Deputy Chief Medical Officer provided a COVID-19 update and discussed Orange County's testing capabilities, CalOptima's COVID-19 response in educating members, and CalOptima's next steps regarding staff maintaining social distancing precautions.

CalOptima Members Experiencing Homelessness Update

Mary Botts, Manager, Enterprise Analytics, presented on members experiencing homelessness. Ms. Botts provided a high-level overview of the CalOptima Homeless Population Clinical Report Card, Medi-Cal Homeless Enrollment Trends, and the Homeless Utilization Trends. Ms. Botts noted that CalOptima's Board of Directors' approved the expansion of the Homeless Clinical Access Program (HCAP) incentives which includes the Clinical Field Teams (CFT) services and telehealth visits.

Federal & State Legislative Update

TC Roady, Director, Regulatory Affairs, provided a verbal update on Governor Newsom's May Revise budget impacts to CalOptima's Medi-Cal members. This budget is scheduled for a final vote on June 15, 2020. Mr. Roady also noted that there were no cuts to the Community Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP) Program.

ADJOURNMENT

Chair Tolbert announced that the next MAC meeting is scheduled for Thursday, August 13, 2020 at 2:30 p.m. Hearing no further business, Chair Tolbert adjourned the meeting at 5:02 p.m.

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

Approved: August 13, 2020

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
3. Consider Election of Officers of the CalOptima Board of Directors

Contact
Richard Sanchez, Interim Chief Executive Officer (714) 246-8400

Recommended Actions
Elect one member of the CalOptima Board of Directors (Board) to serve as Board Chair, and one to serve as Vice Chair through December 31, 2020, or until such time as a successor(s) is elected, unless he, she or they shall sooner resign or be removed from office.

Background/Discussion
Pursuant to Article VIII of the CalOptima Bylaws, the Board is to elect one Director to serve as Chair, and one to serve as Vice Chair. The Chair's role is to serve as the principal officer of the Board, to preside at all meetings of the Board, and to perform other duties as may be prescribed by the Board from time to time. The Vice Chair shall perform the duties of the Chair if the Chair is absent from a meeting or otherwise unable to act.

While the Board typically holds its organizational meeting in June and conducts its annual election of officers at that time, due to the number of Board members completing their service at the June 2020 meeting, the election was delayed until after the new Board members were seated. At this time, with the new Board members now appointed, staff recommends that the Board consider electing officers through December 31, 2020.

Fiscal Impact
The recommended action has no fiscal impact.

Rationale for Recommendation
To ensure continuity in CalOptima's governance, staff recommends that Board members elect a Chair and Vice Chair to preside over CalOptima Board meetings and perform all other duties incident to the offices.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez — *08/26/2020*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing Contract(s)/Contract Amendment(s) with Vendor(s) and Authorizing Unbudgeted Funds to Provide Communication Devices, and Ongoing Service Plans and Related Services to Participants in the CalOptima Program of All-Inclusive Care for the Elderly

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to:
    a. Amend CalOptima's existing contract with Critical Signal Technology, Inc. to include virtual care equipment (smartphones) to be provided along with ongoing voice and data service plans for CalOptima Program of All-Inclusive Care for the Elderly (PACE) participants; and
    b. Extend the existing telehealth application contract with VSee Lab, Inc. (VSee) through June 30, 2021.
2. Authorize unbudgeted expenditures in an amount up to $132,000 from existing reserves to support this initiative through June 30, 2021.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Background

CalOptima PACE currently serves approximately 382 members via the CalOptima PACE center and four operating alternative care settings. PACE is a nursing home alternative for individuals requiring nursing home level of care, but who are able to continue living in the community safely with appropriate support and assistance. The average age of PACE members is 73. PACE members have multiple co-morbidities, presenting as the highest risk population for complications from COVID-19.

CalOptima PACE staff continue to take action to reduce the spread of COVID-19 and maintain the health of CalOptima PACE members in the community. To comply with physical distancing recommendations from the Centers for Disease Control and the California Department of Public Health, PACE congregate services, including center recreational activities and meals, have been suspended. The clinic and rehabilitative therapies operate with limited in-person visits. All other services now rely on drive-thru, telephonic and virtual visits. This reinvention of the CalOptima PACE model into a home-based system of care is being referred to as "PACE Without Walls." As part of the effort, staff obtained approval at the Board's May 7, 2020 meeting to select and contract with a virtual care solution provider (VSee) through the end of Fiscal Year (FY) 2019-20. Until a vaccine or effective therapeutic treatment for COVID-19 is available, CalOptima PACE anticipates most services will be provided through PACE Without Walls.

Back to Agenda

Discussion

Virtual care is a critical tool for staff to support PACE members in their home environment during the coronavirus pandemic. Staff have identified that approximately a third of CalOptima's PACE participants have the physical and cognitive capacity to benefit from virtual encounters, but do not have access to an appropriate device or data services to engage in a video virtual care visit. As such, staff recommends expanding the existing ancillary contract with CST Link to Life to include the types of communication devices that the PACE Interdisciplinary team may authorize to deploy to participant homes. The current contract includes authorization of a Personal Emergency Response System (PERS). This technology essentially allows PACE participants to call for help in an emergency by pushing a button.

Staff recommend amending the contract to also include a senior-friendly smartphone device (i.e., Jitterbug II or similar product) with a front-facing camera for video virtual encounters. While the recommended devices will be regular smartphones that are not limited to just contact with the PACE Center, staff believes that providing PACE participants with smartphones is the most appropriate approach to facilitating PACE Virtual Care in situations when the Member's circumstances make it appropriate. Similar to the PERS device, the smartphone would include an initial activation fee, device fee and monthly service plan fee with sufficient data to engage in virtual visits with PACE clinicians, with all of these expenses covered by CalOptima. As proposed, this will also include enabling the smartphones to access to the virtual care solution telehealth application with selected vendor VSee, and extending the VSee contract through the end of the FY 2020-21.

The authorization process would mirror that of PERS devices. Authorization requests for the smartphones will be reviewed by the individual participant's interdisciplinary care team (IDT) for medical necessity. Authorizations will be approved based on the IDT confirming (1) a need for a reliable device to engage in telehealth encounters, (2) the physical and cognitive abilities to utilize the device, and (3) the participant consents to engaging in telehealth encounters. For authorization extensions, the IDT will also consider the participant's compliance with using the device for PACE-related services. In cases of an expiring authorization, the device would be recovered by PACE staff, device maintenance performed by the vendor and the device re-assigned to a different PACE participant, as authorized by the participant's IDT.

The proposed monthly service plan includes unlimited data and cellular services, with no use restrictions programmed into the device. The smartphones will be property of CalOptima, purchased through a one-time device fee. Through contract language, the vendor will be responsible for initial set-up, installation of the CalOptima PACE virtual care application, VSee, and key phone numbers, maintenance and ongoing technical support.

Staff estimates the unbudgeted expenses to support virtual care for PACE participants for the period of September 1, 2020, through June 30, 2021, is $132,000. Specifically, up to $105,000 to amend the

Back to Agenda

contract with Critical Signal Technology, Inc., and up to $27,000 to extend the contract with VSee. These amounts include fees for:

- 12 months of telehealth application services with VSee;
- 151 projected devices and activation; and
- 1,404 member months for service plans.

Devices and activation fees are one-time expenses. CalOptima may cancel, increase, or decrease the number of devices under a service plan on a monthly basis. There is no minimum contract commitment for the service plan.

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 contract amendment and the program implemented thereby are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact
The recommended action to amend the contract with Critical Signal Technology, Inc., and extend the VSee contract to support virtual care services for PACE participants in response to COVID-19 is an unbudgeted item. An allocation of up to $132,000 from existing reserves will fund this action. If expenses are anticipated beyond June 30, 2021, Staff will address them in future operating budgets or through separate Board actions.

Rationale for Recommendation
Access to virtual care is critical for PACE participants to remain safe at home during the Coronavirus pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. May 7, 2020 Board Action Authorizing Contracts and Funding to Support the CalOptima PACE Response to COVID-19

/s/ Richard Sanchez *08/26/2020*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Critical Signal Technologies / GTL, Incorporated dba Link to Life	27475 Meadowbrook Road	Novi	MI	48377
Vsee Labs, Inc.	3188 Kimlee Drive, Suite 100	San Jose	CA	95132

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Authorizing Contracts and Funding to Support the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Response to COVID-19

Contact
David Ramirez, M.D., Chief Medical Officer (714) 246-8400

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

1. Virtual care solution provider for PACE members recommended by staff through an informal bidding process for the period of May 1, 2020, through June 30, 2020, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $9,500; and

2. Mobile phlebotomy services provider for blood draw services in PACE member homes for the period of April 1, 2020, through June 30, 2020, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $12,000.

Background
CalOptima PACE currently serves approximately 402 members via the CalOptima PACE center and four operating alternative care settings. Eligibility for PACE is based on individuals requiring nursing home level of care, yet able to continue living in the community safely. The average age of PACE members is 73. PACE members have multiple co-morbidities, presenting as the highest risk population for complications from COVID-19.

Staff are taking definitive action to reduce the spread of COVID-19 and maintain the health of PACE members in the community. The operational changes made thus far represent a significant reinvention of the PACE model to a home-based system of care and support. At this time, the PACE center is closed to visitors. To comply with social distancing recommendations from the Centers for Disease Control (CDC), PACE day center services have been suspended. The clinic continues to operate with extremely limited in-person visits, now relying on drive-thru, telephonic and virtual visits. These operational changes to remote monitoring, telehealth and delivery of critical supplies and medications has been built upon existing contractual relationships. As services gaps are identified, staff plans to continue to recommend additional contractual relationships to meet member needs.

Discussion
Virtual care is a valuable tool for staff to support PACE members in their home environment. As an interim solution, PACE is using FaceTime and GoogleDuo to connect with members and provide virtual visits for doctors, nurses, therapists and social workers. The current COVID-19 response is expected to extend into the coming months and staff recommend a HIPAA-compliant, cross platform virtual care solution. An interdepartmental team of CalOptima staff, including PACE management, Information Services (Security and Applications) managers, a purchasing manager and the Privacy Officer has

reviewed potential solutions based on an established scope of work. Staff estimate that the cost for these services will range from $200 to $1,000 per month, but will vary depending on vendor packages and the number of virtual care users. In accordance with CalOptima Purchasing Policy GA.5002, staff recommend that the Board authorize the CEO to select a vendor based on an informal bidding process, which includes vendor demonstrations of each product in the context of CalOptima system requirements, entering into an agreement with the selected vendor, and the expenditure of unbudgeted funds from reserves in an amount up to $9,500 to cover anticipated licensing fees and associated expenses with virtual care implementation through June 30, 2020.

While virtual care is a valuable tool, not all provider encounters can be accomplished through a virtual platform. Physical components, such as the collection of vitals and blood draws, usually completed in the PACE clinic, are not possible remotely. To reduce the risk of PACE members going to the PACE clinic or a contracted laboratory for blood draw services, staff recommend contracting with a mobile phlebotomy service provider capable of completing home visits for stat and routine blood draw services, including venipuncture blood draws, capillary blood draws, kit draws, as well as specimen collection. Providers in this market often contract for a case or capitated rate. This type of bundled rate structure is common for mobile phlebotomy contracts with HMO, IPA, and other health providers in the community. Staff recommend contracting for a flat rate of up to $65 per visit, to include supplies, order processing, technician personnel, and transportation to reach the member and deliver the specimen to the PACE contracted lab. Access to this service is critical in response to COVID-19, and is also expected to be beneficial post-public health crisis for weekend and stat laboratory orders.

Fiscal Impact

The recommended actions to contract with a telehealth solution for PACE members for the period of May 1, 2020, through June 30, 2020, and to contract with a mobile phlebotomy services provider for the period of April 1, 2020, through June 30, 2020, are unbudgeted items. The fiscal impact to the current year operating budget for both is estimated at $21,500. An allocation from existing reserves will fund the recommended actions. If expenses are anticipated beyond June 30, 2020, staff will address them in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions.

Rationale for Recommendation

Access to telehealth and mobile in-home phlebotomy are critical to the reinvented PACE model operating in response to COVID-19.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *04/29/2020*

Authorized Signature **Date**

Attachment 1 to May 7, 2020 Board of Directors Meeting– Agenda Item 9

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Doxy LLC	3563 S. Mustang Drive	Ontario	CA	91761
Vsee Labs, Inc.	3188 Kimlee Drive, Suite 100	San Jose	CA	95132
SnapMD, Inc.	121 Lexington Drive, Suite 412	Glendale	CA	91203
Thera-Link	P.O. Box 13709	Birmingham	AL	35202
PhlebExpress	32819 Temecula Pkwy. Suite B	Temecula	CA	92591

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Adoption of Resolution Approving and Adopting Updated Human Resources Policies

Contact
Brigette Gibb, Executive Director, Human Resources, (714) 246-8400

Recommended Actions
Adopt Resolution Approving CalOptima's Updated Human Resources Policies:

1. GA.8037 Leave of Absence;
2. GA.8052 Drug-Free & Alcohol-Free Workplace; and
3. GA.8058 Salary Schedule

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

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

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

Policy No./Name	Summary of Changes	Reason for Change
GA.8037 Leave of Absence	• Addition of a statement identifying eligibility for payment of supplemental compensation while on Leave of Absence (LOA). • Included additional edits to address other forms of supplemental compensation that might be impacted as a result of a continuous LOA. • Addition of a statement that employees are not permitted to undertake other employment while on LOA. • Attachment A (Leave of Absence Request Form)	• This policy outlines the general rules and restrictions applicable to a Leave of Absence. • Annual review of the policy. • Revised content to clarify and reflect current practices.

Back to Agenda

	○ Minor revision - Addition of another statement for Reason for Leave	
GA.8052 Drug-Free & Alcohol-Free Workplace	• Addition of a statement noting cannabis products are illegal drugs • Revision of the definition of CalOptima property for clarity. • Clarification of a supervisor's responsibility in observing, reporting and documenting a reasonable suspicion that an employee may be under the influence while on-duty or on CalOptima Property. • Clarification of types of drug testing, scope of testing and options for managing a positive test. • Attachment A (Drug and Alcohol Reasonable Suspicion Checklist) ○ Addition of indicators from the Dept of Transportation Alcohol & Drug Impairment Indicator checklist.	• This policy establishes guidelines for a drug-free and alcohol-free workplace at CalOptima and CalOptima PACE to enhance safety in the workplace ,promote employee health, maintain a high level of quality in service to CalOptima's members, ensure productivity, protect against liability, and promote the public's trust in CalOptima. • Annual review of the policy. • Revised content for the purpose of clarifying language for ease of comprehension and consistent application of current practices.
GA.8058 Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment A – Salary Schedule has been revised in order to reflect recent changes, including the addition of 12 new position titles. A summary of the changes to the Salary Schedule Attachment A is included for reference.	• Pursuant to CalPERS requirement, 2 CCR §570.5 • CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. • New Position: Creation of a new job title may be due to a regulatory requirement, a change in the scope of a current position or the addition of a new level in a job family.

Back to Agenda

Fiscal Impact
The recommended action to update CalOptima Policies GA.8037 and GA.8052 is budget neutral.

The recommended action to update CalOptima Policy GA.8058, including the addition of 12 new titles to the Salary Schedule, has no fiscal impact.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 20-0903-01, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
   a. GA.8037 Leave of Absence with revised Attachment A (redlined and clean copies)
   b. GA.8052 Drug-Free & Alcohol-Free Workplace with revised Attachment A (redlined and clean copies)
   c. GA.8058 Salary Schedule with revised Attachment A (redlined and clean copies)
3. Summary of Changes to Salary Schedule

/s/ Richard Sanchez — *08/26/2020*
Authorized Signature — **Date**

Back to Agenda

RESOLUTION NO. 20-0903-01

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

APPROVE UPDATED HUMAN RESOURCES POLICIES

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies:

a. GA.8037 Leave of Absence
b. GA.8052 Drug-Free & Alcohol-Free Workplace
c. GA.8058 Salary Schedule

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this September 3, 2020.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: _____Chair, CalOptima Board of Directors

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

Back to Agenda Back to Item

Policy:	GA.8037
Title:	**Leave of Absence**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence.

II. POLICY

A. Granting a Leave of Absence: CalOptima will grant a Leave of Absence (LOA) to eligible employees in accordance with CalOptima's respective policies and procedures. For leaves specified herein, an employee must submit a LOA request form to the Human Resources (HR) Department.

B. An employee's manager may approve up to five (5) scheduled workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of PTO time for pre-planned vacations does not require HR approval.

C. If an employee requires additional time off work beyond the amount of time authorized herein, and his or her manager and HR grant Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

D. Types of LOA:

1. Pregnancy Disability Leave (PDL): Under California Pregnancy Regulations, employers must provide up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid disability leave per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence.

2. Family and Medical Leave: Under the Family and Medical Leave Act (FMLA), employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month period. In most circumstances, FMLA leave will run at the same time as Pregnancy Disability Leave or California Family Rights Act (CFRA) leave (see below), where

Back to Agenda Back to Item

applicable, and is not in addition to those leaves, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and CFRA Leaves of Absence.

3. California Family Rights Leave: The California Family Rights Act (CFRA) provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month period, as detailed in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

4. Military Family Leave: Eligible employees may take an unpaid leave of absence under FMLA and CFRA to care for a spouse, child, or parent who is on covered active duty or has been notified of an impending call or order to active duty. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered service-member with a qualifying serious injury or illness during a single twelve (12) month period, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

5. Military Service Leave: The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a Federal law that provides a cumulative of five (5) years of leave (with certain exceptions) and re-employment rights for veterans and members of the National Guard and Reserve following qualifying military service. USERRA requires that a person re-employed under its provisions be given credit for any months he or she would have been employed but for the military service in determining eligibility for FMLA leave. A person re-employed following military service should be given credit for the period of military service towards the months-of-employment eligibility requirement.

    a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to his or her full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of his or her absence while he or she is engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

    b. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima in the month prior to the leave of absence, assuming the amount the employee earned at CalOptima is greater than his or her military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima's payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima base salary, CalOptima will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the leave of absence will be unpaid.

6. Military Spouse Leave: Pursuant to Military & Veterans Code, Section 395.10, eligible employees may take up to ten (10) scheduled workdays of unpaid leave when their spouse is on

leave from active duty in the U.S. Armed forces, Reserves or National Guard. Employee may use accrued paid time off (PTO) if sufficient PTO is accrued or may take this time as unpaid.

7. Workers' Compensation: In accordance with state law, CalOptima provides Workers' Compensation insurance coverage for employees in case of work-related injury. CalOptima may grant a leave of absence subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.

8. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly scheduled working hours for jury duty, provided they remit the jury fee, excluding payments for mileage, to CalOptima. CalOptima may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima's members.

9. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (suspension of pupil), subject to limitations under applicable laws. Accrued paid time off (PTO) shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Policy GA.8018: Paid Time Off (PTO) and the CalOptima Employee Handbook under Time Off to Appear in Pupil's School.

10. Bereavement Leave: With approval of an employee's manager, an employee may take up to three (3) scheduled workdays off with pay (maximum of twenty-four (24) hours) in the event of a death of an employee's: current spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. Supporting documentation for bereavement leave must be submitted to Payroll within thirty (30) calendar days of leave. The employee's manager may approve additional time off of up to five (5) scheduled work days to be taken as either PTO, or unpaid time off. An employee must submit a LOA request form to HR and request a Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence if the employee plans to take additional unpaid time off exceeding five (5) scheduled workdays.

11. Victims of Domestic Violence, Sexual Assault or Stalking Leave: Subject to the requirements under Labor Code, Sections 230 and 230.1, an employee who is a victim of domestic violence, sexual assault, or stalking, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. Employees may elect to use accrued PTO, if available, when a LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. After an employee exhausts his or her PTO accruals, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

a. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;

b. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;

c. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking;

d. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation; and/or

e. To obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relieve, to help ensure the health, safety, or welfare of the employee, or his or her child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, Section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled workdays per calendar years for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled workdays per calendar year (three (3) scheduled work days maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

E. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

F. Other Leaves: Please refer to CalOptima Policy GA.8038: Personal Leave of Absence.

G. To the extent that this policy conflicts with CalOptima Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave, or GA.8040: Family and Medical Leave Act and California Family Rights Act Leave, those specific policies shall supersede. To the extent this policy conflicts with the CalOptima Employee Handbook, this policy shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a LOA, CalOptima shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a release to return to work from his or her health care provider (where applicable) stating that he or she is able to resume work. CalOptima also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the time period an employee is on active duty, or utilizing PTO for an approved LOA. Once an employee elects not to use PTO accruals or exhausts all PTO accruals, the remaining time off for an approved LOA shall not be considered time worked for purposes of accruing PTO hours.

C. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement.

D. Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, or Automobile Allowance during his/her LOA. An employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution or Supplemental Retirement Benefit during any portion of a paid LOA, but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for the LOA time period, and executives must be on active status at the time the executive incentive is paid out in order to be eligible to receive the executive incentive. Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

~~D.~~E. Documentation: Failure to provide all the required information and/or documentation within the requested or required timeframe may result in a delay in CalOptima's approval of the LOA request; CalOptima's denial of the employee's request for a LOA; an impact to the employee's ability to take a LOA as requested; and/or disciplinary action, up to and including termination.

~~E.~~F. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not obtained an extension from HR prior to such expiration date, the employee will be considered to have voluntarily resigned.

~~F.~~G. Misrepresentations: Misrepresenting reasons for applying for a LOA will result in disciplinary action, up to and including termination.

~~G.~~H. Health benefits for PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: Employer payments towards health benefits (medical, vision, and dental) for PDL, FMLA, CFRA, Military Service, or Workers' Compensation LOAs, will not continue beyond the FMLA/CFRA covered period pursuant to CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave. Employees may elect to purchase continuation of such health benefits coverage through COBRA. When an employee returns to work, the eligibility and accrual dates for such benefits may be adjusted to reflect the period of the LOA.

I. Employees may not engage in outside work for other employers while on an approved leave of absence from CalOptima, other than military service.

~~H.~~J. Other benefits: All other benefits not specified herein provided by CalOptima shall be administered according to HR procedures.

~~I.~~K. Eligibility and Specific Leave Requirements: Refer to specific CalOptima policies listed below for detailed information about eligibility and other leave requirements:

1. CalOptima Policy GA.8018: Paid Time Off (PTO);
2. CalOptima Policy GA.8038: Personal Leave of Absence;
3. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence;
4. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave; and/or
5. CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.

IV. ATTACHMENT(S)

A. Leave of Absence Request Form

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off (PTO)
C. CalOptima Policy GA.8038: Personal Leave of Absence
D. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence
E. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave
~~E.~~F. CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.
~~F.~~G. Government Code, §12945.1 et seq. (CFRA)
~~G.~~H. Labor Code, §230 et seq. (Jury service and other leaves)
~~H.~~I. Military & Veterans Code, §395.10 (Military Service Leave)
~~I.~~J. Title 2, California Code of Regulations (C.C.R.), §7291.2 et seq. (Pregnancy Regulations)
~~J.~~K. Title 2, California Code of Regulations (C.C.R.), §7293.5 et seq. (Disability Regulations)
~~K.~~L. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
~~L.~~M. Title 29, United States Code (U.S.C.), §2601 et seq. (FMLA)
~~M.~~N. Title 38, United States Code (U.S.C.), §4301 et seq. (USSERA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	05/04/2017	GA.8037	Leave of Absence	Administrative
Revised	08/03/2017	GA.8037	Leave of Absence	Administrative
Revised		GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of his or her child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

Policy:	GA.8037
Title:	**Leave of Absence**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence.

II. POLICY

A. Granting a Leave of Absence: CalOptima will grant a Leave of Absence (LOA) to eligible employees in accordance with CalOptima's respective policies and procedures. For leaves specified herein, an employee must submit a LOA request form to the Human Resources (HR) Department.

B. An employee's manager may approve up to five (5) scheduled workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of PTO time for pre-planned vacations does not require HR approval.

C. If an employee requires additional time off work beyond the amount of time authorized herein, and his or her manager and HR grant Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

D. Types of LOA:

1. Pregnancy Disability Leave (PDL): Under California Pregnancy Regulations, employers must provide up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid disability leave per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence.

2. Family and Medical Leave: Under the Family and Medical Leave Act (FMLA), employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month period. In most circumstances, FMLA leave will run at the same time as Pregnancy Disability Leave or California Family Rights Act (CFRA) leave (see below), where

Back to Agenda Back to Item

applicable, and is not in addition to those leaves, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and CFRA Leaves of Absence.

3. California Family Rights Leave: The California Family Rights Act (CFRA) provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month period, as detailed in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

4. Military Family Leave: Eligible employees may take an unpaid leave of absence under FMLA and CFRA to care for a spouse, child, or parent who is on covered active duty or has been notified of an impending call or order to active duty. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered service-member with a qualifying serious injury or illness during a single twelve (12) month period, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

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    a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to his or her full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of his or her absence while he or she is engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

    b. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima in the month prior to the leave of absence, assuming the amount the employee earned at CalOptima is greater than his or her military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima's payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima base salary, CalOptima will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the leave of absence will be unpaid.

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7. Workers' Compensation: In accordance with state law, CalOptima provides Workers' Compensation insurance coverage for employees in case of work-related injury. CalOptima may grant a leave of absence subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.

8. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly scheduled working hours for jury duty, provided they remit the jury fee, excluding payments for mileage, to CalOptima. CalOptima may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima's members.

9. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (suspension of pupil), subject to limitations under applicable laws. Accrued paid time off (PTO) shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Policy GA.8018: Paid Time Off (PTO) and the CalOptima Employee Handbook under Time Off to Appear in Pupil's School.

10. Bereavement Leave: With approval of an employee's manager, an employee may take up to three (3) scheduled workdays off with pay (maximum of twenty-four (24) hours) in the event of a death of an employee's: current spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. Supporting documentation for bereavement leave must be submitted to Payroll within thirty (30) calendar days of leave. The employee's manager may approve additional time off of up to five (5) scheduled work days to be taken as either PTO, or unpaid time off. An employee must submit a LOA request form to HR and request a Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence if the employee plans to take additional unpaid time off exceeding five (5) scheduled workdays.

11. Victims of Domestic Violence, Sexual Assault or Stalking Leave: Subject to the requirements under Labor Code, Sections 230 and 230.1, an employee who is a victim of domestic violence, sexual assault, or stalking, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. Employees may elect to use accrued PTO, if available, when a LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. After an employee exhausts his or her PTO accruals, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

a. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;

b. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;

c. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking;

d. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation; and/or

e. To obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relieve, to help ensure the health, safety, or welfare of the employee, or his or her child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, Section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled workdays per calendar years for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled workdays per calendar year (three (3) scheduled work days maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

E. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

F. Other Leaves: Please refer to CalOptima Policy GA.8038: Personal Leave of Absence.

G. To the extent that this policy conflicts with CalOptima Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave, or GA.8040: Family and Medical Leave Act and California Family Rights Act Leave, those specific policies shall supersede. To the extent this policy conflicts with the CalOptima Employee Handbook, this policy shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a LOA, CalOptima shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a release to return to work from his or her health care provider (where applicable) stating that he or she is able to resume work. CalOptima also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the time period an employee is on active duty, or utilizing PTO for an approved LOA. Once an employee elects not to use PTO accruals or exhausts all PTO accruals, the remaining time off for an approved LOA shall not be considered time worked for purposes of accruing PTO hours.

C. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement.

D. Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, or Automobile Allowance during his/her LOA. An employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution or Supplemental Retirement Benefit during any portion of a paid LOA, but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for the LOA time period, and executives must be on active status at the time the executive incentive is paid out in order to be eligible to receive the executive incentive. Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

E. Documentation: Failure to provide all the required information and/or documentation within the requested or required timeframe may result in a delay in CalOptima's approval of the LOA request; CalOptima's denial of the employee's request for a LOA; an impact to the employee's ability to take a LOA as requested; and/or disciplinary action, up to and including termination.

F. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not obtained an extension from HR prior to such expiration date, the employee will be considered to have voluntarily resigned.

G. Misrepresentations: Misrepresenting reasons for applying for a LOA will result in disciplinary action, up to and including termination.

H. Health benefits for PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: Employer payments towards health benefits (medical, vision, and dental) for PDL, FMLA, CFRA, Military Service, or Workers' Compensation LOAs, will not continue beyond the FMLA/CFRA covered period pursuant to CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave. Employees may elect to purchase continuation of such health benefits coverage through COBRA. When an employee returns to work, the eligibility and accrual dates for such benefits may be adjusted to reflect the period of the LOA.

I. Employees may not engage in outside work for other employers while on an approved leave of absence from CalOptima, other than military service.

J. Other benefits: All other benefits not specified herein provided by CalOptima shall be administered according to HR procedures.

K. Eligibility and Specific Leave Requirements: Refer to specific CalOptima policies listed below for detailed information about eligibility and other leave requirements:

1. CalOptima Policy GA.8018: Paid Time Off (PTO);

2. CalOptima Policy GA.8038: Personal Leave of Absence;

3. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence;

4. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave; and/or

5. CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.

IV. ATTACHMENT(S)

A. Leave of Absence Request Form

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off (PTO)
C. CalOptima Policy GA.8038: Personal Leave of Absence
D. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence
E. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave
F. CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.
G. Government Code, §12945.1 et seq. (CFRA)
H. Labor Code, §230 et seq. (Jury service and other leaves)
I. Military & Veterans Code, §395.10 (Military Service Leave)
J. Title 2, California Code of Regulations (C.C.R.), §7291.2 et seq. (Pregnancy Regulations)
K. Title 2, California Code of Regulations (C.C.R.), §7293.5 et seq. (Disability Regulations)
L. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
M. Title 29, United States Code (U.S.C.), §2601 et seq. (FMLA)
N. Title 38, United States Code (U.S.C.), §4301 et seq. (USSERA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	05/04/2017	GA.8037	Leave of Absence	Administrative
Revised	08/03/2017	GA.8037	Leave of Absence	Administrative
Revised		GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of his or her child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT

Contact Phone Number:_____

Employee Name: _____ Employee ID #: _____

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/___/____

Is Illness/Injury Work Related?

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave –** Must be approved by Manager/Director

☐ **Intermittent** (taken in separate blocks of time)

☐ **Other -** _____(Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/___/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)

Manager/Director Signature: _____ Date:____/___/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA

FMLA/CFRA Hours Balance Available _____

Last Day Worked _____

Return from Leave Date _____

Human Resources Signature: _____ Date:____/___/____

COMMENTS_____

Rev: ~~0921162~~2020

CalOptima
A Public Agency
Better. Together.

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FMLA/CFRA Hours Balance Available _____

Last Day Worked _____

Return from Leave Date _____

Human Resources Signature: _____ Date:____/____/____

Back to Agenda Back to Item

COMMENTS_____

Rev: 2020

Policy:	GA.8052
Title:	**Drug-Free and Alcohol-Free Workplace**
Department:	Human Resources
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	02/01/2014
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines for a drug-free and alcohol-free workplace at CalOptima and CalOptima PACE to further enhance safety in the workplace for all employees, promote employee health, maintain a high level of quality in service to CalOptima's ~~members~~Members, ensure productivity, protect against liability, and promote the public's trust in CalOptima. ~~It is well documented that substance~~Substance abuse, including the misuse of both legal and illegal drugs, in the workplace can negatively impact employee performance, ~~worker~~employee safety, and/or safety of the ~~general~~ public. ~~-~~For the purposes of this Policy, and in accordance with federal law, marijuana and other cannabis products fall under the category of "illegal drugs."

II. POLICY

A. CalOptima has a vital interest in maintaining a safe and productive work environment for its employees, Members, and those who come into contact with CalOptima. To support this interest, CalOptima shall maintain a workplace that is free of alcohol, illegal drugs, and controlled substances and herein discourages alcohol and substance abuse by its employees.

B. The following behavior ~~shall constitute violation~~while on duty or on CalOptima Property are separately, or in combination violations of CalOptima's ~~drug-free workplace~~Drug-Free and Alcohol-Free Workplace Policy:

1. The unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance;

2. Possession~~,~~ or use~~,~~ of alcohol~~,~~ or an illegal or controlled substance, or being under the influence of alcohol~~,~~ or an illegal or controlled substance, while on ~~the job~~duty, or on or in CalOptima Property, except where the controlled substance is lawfully prescribed and used consistent with a doctor's authorization;

3. Abuse of a legal drug, or the purchase, sale, manufacture, distribution, dispensation of any legal prescription drug in a manner inconsistent with the law;

Back to Agenda Back to Item

4. ~~Driving~~Operating a CalOptima owned~~,~~ or leased~~,~~ vehicle or conducting CalOptima business in a personal vehicle while under the influence of alcohol, illegal drugs, or controlled substance; and

5. Distribution, sale, or purchase of alcohol and/or an illegal or controlled substance while on ~~the job~~ duty or on or in CalOptima Property.

C. This Policy and each of its rules apply:

1. Whenever an employee is on~~,~~ or in~~,~~ CalOptima Property~~, which shall include the CalOptima PACE Center, surrounding grounds, parking lots, and leased, or rented, spaces~~;

2. During ~~CalOptima and CalOptima PACE~~ company time (includes~~,~~ breaks, meal periods, and work duties offsite (e.g., representing CalOptima at community functions or meetings, meeting with Members, or providers, etc.));

3. In any vehicle used on ~~CalOptima and CalOptima PACE~~ company business; and

4. In other circumstances (such as on customer premises, or at business/sales functions) that may adversely affect CalOptima's operations, safety, reputation and/or the administration of this Policy.

D. It is the policy of CalOptima and a condition of employment that an employee be present and able to physically and mentally perform his/her job free from the effects of alcohol, narcotics, depressants, stimulants, hallucinogens, and cannabis, or any other substances which can impair job performance.

E. Violation of this Policy ~~and standards of conduct~~ will not be tolerated, and CalOptima shall take appropriate actions, including, but not limited to, ~~employee discipline~~corrective action, up to and including termination, to protect, as fully as possible, all CalOptima employees and members of the public. CalOptima may also bring the matter to the attention of appropriate law enforcement authorities and/or professional licensing ~~authority~~authorities.

III. PROCEDURE

A. Prohibitions: ~~The following rules are extremely important, and an~~An employee who violates any one (1) of ~~them~~these prohibitions shall be subject to ~~disciplinary~~corrective action, up to and including termination:

1. Alcohol: An ~~Employee~~employee may not possess, distribute, dispense, sell, use, transfer, offer, or be under the influence of any intoxicating liquor such that the employee's blood alcohol concentration (BAC) is .04, or above, while at work, or on ~~-~~duty for CalOptima business. Off-duty use of alcohol that adversely affects, or impairs, an employee's job performance, or results in on-duty conduct which adversely affects, or threatens to adversely affect, CalOptima's interest is prohibited.

a. This rule prohibits using any alcohol prior to reporting to work such that the employee's BAC is .04~~,~~ or above~~,~~ during breaks~~,~~ or meal periods, or in conjunction with any CalOptima activity, except social~~,~~ or business~~,~~ events where the Chief Executive Officer and/or other members of the Executive Staff has/have authorized the moderate consumption of alcoholic beverages.

b. An employee at work~~,~~ or on ~~-~~duty, for CalOptima business with a BAC level at.04, or above, shall be removed from duty and may be subject to disciplinary action, up to and including termination.

2. Drugs: An ~~Employee~~employee may not possess, distribute, dispense, sell, use, transfer, offer, share, attempt to sell, or obtain, manufacture, or be under the influence of any illegal drug~~,~~ or controlled substance, or have any trace of illegal drugs~~,~~ or controlled ~~substances,~~substance present in the body~~,~~ while at work~~,~~ or on duty for CalOptima business. Therefore, an employee who tests positive for any illegal drug~~,~~ or controlled substance~~,~~ will be deemed to have violated this rule.
   a. This rule also prohibits prescription drugs being taken while on duty without a doctor's authorization.

   b. Abuse of a legal drug or the purchase, sale, manufacture, distribution, dispensation of any legal prescription drug in a manner inconsistent with the law is also prohibited under this rule.

3. Prescriptions/Over–The-Counter Medications: ~~It~~An employee~~ is the Employee's responsibility to check~~responsible for checking the potential side effects of prescription drugs and over-the-counter medications with their doctor~~,~~ or pharmacist~~,~~ before reporting to work, and to immediately let their supervisor know when such use makes it unsafe for them to report to work~~,~~ or do their job.

4. Adulterants: ~~Employees are~~ An employee is prohibited from ~~possessing~~using any substance that is used for the purpose of manipulating the results of a drug test.

~~B. Employees are responsible for following all of CalOptima's work and safety rules and policies, and for observing the standards of behavior that the employer, coworkers, and Members have the right to expect from a CalOptima employee.~~

~~C.~~B. Pre-Employment Testing: All employees in Safety Sensitive ~~Employees~~classifications are required to pass a pre-employment urine drug test as a condition of employment in the classification.

~~D.~~C. Random Drug Testing: Effective thirty (30) calendar days after the adoption of this Policy, the following shall apply:

1. All CalOptima employees ~~that~~who provide health care services and personal care services to CalOptima Members may be subject to random drug testing. This shall include any employee who operates a CalOptima owned~~,~~ or leased~~,~~ motor vehicle.

2. All CalOptima employees ~~that~~who have face-to-face interaction in the residence of a Member, or prospective Member, and provide health care services, or personal care services, such as nurses in the field, may be subject to random drug testing.

~~E.~~D. Mandatory Post Traffic Accident Testing: ~~If~~When a CalOptima employee is involved in a work-related traffic accident, CalOptima shall request a drug and/~~or~~ alcohol ~~testing~~ test if there is a reasonable suspicion of the involvement of drugs and/or alcohol.

~~F.~~E. Reasonable Suspicion Testing~~,~~ or Reasonable Cause

1. ~~A~~If a supervisor ~~who~~, Human Resources and/or Manager, Environmental Health and Safety suspects an employee is under the influence of drugs and/or alcohol and observes ~~one (1),~~two (2) or more~~,~~ of the following, shall immediately notify the Human Resources Department and submit a completed *Drug And Alcohol Reasonable Suspicion Checklist* form to the Human Resources Department within twenty-four (24) hours:

   a. ~~Observable symptoms, or unusual behavior (~~Difficulty walking such as swaying, ~~unsteady~~an unstable gait, staggering, or stumbling, ~~flushed, etc.);~~especially when not consistent with the employee's normal behavior;

   b. Flushed skin;

   ~~b.~~c. Bloodshot eyes and/or inability to make eye contact;

   ~~c.~~d. Slurred speech;

   ~~d.~~e. Odor~~, or smell,~~ of alcohol~~,~~ or drugs~~,~~ on the employee's breath~~,~~ ~~or~~ clothes, or in an area (such as in a vehicle, office, work area, or restroom) immediately controlled~~,~~ or occupied, by the employee;

   ~~e.~~f. Alcohol, alcohol containers, illegal drugs, or drug paraphernalia in the employee's possession, or in an area controlled~~,~~ or occupied~~,~~ by the employee (such as in a vehicle, office, ~~desk~~work area, or restroom);

   ~~f.~~g. Unexplained~~,~~ or significant~~,~~ deterioration in job performance;

   ~~g.~~h. Unexplained significant changes in behavior (e.g., lethargy, abusive behavior, repeated disregard of safety rules, or procedures, insubordination, etc.);

   ~~h.~~i. Unexplained absenteeism~~,~~ or tardiness;

   ~~i.~~j. Employee admissions regarding drug~~,~~ or alcohol use; and/or

   ~~j.~~k. ~~Any involvement~~Involvement in any work-related accident~~,~~ or near misses.

2. If a Human Resources representative or the Manager of Environmental Health and Safety or the supervisor along with the Human Resources ~~Department concludes~~Representative or Manager of Environmental Health and Safety have reasonable suspicion that an employee may be under the influence of or has consumed drugs~~,~~ or alcohol~~,~~ while on-duty ~~for~~or on CalOptima ~~business,~~Property, CalOptima may direct the employee ~~may be requested~~ to ~~consent to an~~undergo a drug and alcohol ~~and/or drug~~ test. If the employee refuses to ~~consent to~~undergo the test, such refusal may result in ~~disciplinary~~corrective action, up to and including termination from employment.

3. The supervisor and/or Human Resources representative ~~should~~or the Manager of Environmental Health and Safety will inform the employee about the consequences to the employee if the drug and alcohol ~~and/or drug~~ test is positive, which shall include ~~disciplinary~~corrective action, up to and including termination from employment, and/or required admission to a drug and/or alcohol treatment program.

4. If appropriate, ~~the~~ Human Resources representative may assist the employee in making arrangements to be taken home after a drug and/or alcohol test is completed. CalOptima employees who are not relatives of the employee may not provide the transportation themselves.

~~G.~~F. Scope of Tests: All tests shall be conducted by a certified laboratory. ~~CalOptima employees~~Employees may be tested for, but not limited to~~,~~ the following ~~substances~~:

1. Alcohol;

2. Amphetamines, or other stimulants;

3. Cannabinoids (THC), such as marijuana and hashish;

4. Cocaine;

5. Opiates, or other narcotics;

6. Phencyclidine; and

7. Barbiturates, or other depressants.

~~H.~~G. Positive Tests: If a positive test result can be explained by the legal use of any substance, an employee may present verification by a licensed medical professional. Any employee who tests positive for drugs that are not prescribed to him or her by ~~a physician shall be~~their physician will be immediately removed from duty. Additionally, corrective action will be taken which may include:

1. ~~Immediately removed from his or her duty and/or disciplined~~Corrective action, up to and including termination;

2. ~~Referred~~Referral to a substance abuse professional for assessment and recommendations;

3. ~~Required~~Requirement to pass a Return-to-Duty test; ~~and~~ or

4. ~~Required~~Requirement to sign a Return-to-Work Agreement.

~~I.~~H. Confidentiality: CalOptima shall maintain all drug-testing information in separate confidential records.

~~J.~~I. Employee Assistance Program:

1. ~~CalOptima's commitment~~CalOptima is committed to ~~help~~helping employees remain productive members of CalOptima's team. CalOptima provides an Employee Assistance Program (EAP) for employees to provide counseling and other services for employees with substance abuse and other personal~~,~~ or emotional~~,~~ problems that can affect work performance. The EAP will treat information obtained regarding an ~~Employee~~employee during participation in such program~~,~~ or services, as confidential in accordance with Federal and State laws.

2. ~~If an employee believes him or herself to have a problem with drugs or alcohol, that employee is responsible for seeking assistance, whether from, or through, CalOptima, or any other resource, before a drug, or alcohol, problem adversely affects his or her work performance, or results in a violation of this policy.~~ No employee shall ~~be disciplined,~~receive corrective action

or discriminated against~~,~~ for simply seeking help from the EAP, if such help or request ~~occurs~~for help is prior to a violation of this Policy.

3. In certain circumstances, CalOptima may insist upon a mandatory referral to CalOptima's EAP as a condition of continued employment.

~~K.~~J. Condition of Continued Employment: If a ~~professional assessment is made that the employee has a problem with drugs and/or alcohol, his or her~~violation of the Policy has occurred continued employment with CalOptima may be conditioned upon:

1. Entering into and completing a treatment program approved by CalOptima;

2. Signing and complying with a last chance performance agreement; and/or

3. Undergoing ~~continuous~~ random drug and/or alcohol ~~testing at CalOptima's discretion~~test for a specified period of time.

~~L.~~K. Fit for Duty:

1. CalOptima may require a fit for duty exam by a certified medical practitioner. This exam may be administered along with a drug ~~and/or alcohol screen~~test to determine if the employee is fit for duty.

~~M.~~L. Duty to Cooperate:

1. ~~An employee who fails~~As a condition of continued employment, employees are expected to cooperate ~~in~~with the full administration of this ~~policy shall be terminated.~~Policy. Violation of this ~~policy~~Policy includes, but is not limited to:

   a. Refusing to ~~consent to~~ participate in testing, ~~to~~ submit a sample, or ~~to~~ sign required forms;

   b. Refusing to cooperate in any way (for example, refusing to courteously and candidly cooperate in any interview or investigation, including any form of ~~truthfulness~~untruthfulness, misrepresentation, ~~or~~ misleading statements, or omissions);

   c. Any form of dishonesty in the ~~investigation, or~~ testing process or related investigation;

   d. Refusing to test again at a time of CalOptima's choosing whenever any test results in a finding of a dilute sample, or reasonable suspicion; and/or

   ~~e.~~ Failure to ~~accept the referral, to enter into and complete an approved treatment program, or to sign or~~ adhere to the ~~commitments in the Last Chance Performance Agreement.~~

   ~~f.~~e. ~~An employee who fails to cooperate in the administration~~conditions of ~~this policy shall be terminated~~continued employment.

~~N.~~M. Self-Disclosure of Convictions: Employees are required to report any drug and/or alcohol related convictions occurring outside of the workplace to CalOptima within five (5) calendar days of such conviction. Failure to do so is considered a violation of this Policy. This information may subject the employee to ~~disciplinary~~corrective action, random testing requirements, referral to the EAP, and/or may be reported to the appropriate licensing authority.

IV. ATTACHMENT(S)

A. Drug and Alcohol Reasonable Suspicion Checklist

V. REFERENCE(S)

A. California Drug-Free Workplace Act of 1990 (California Government Code, §§8350-8351 and 8355-8357)
B. CalOptima Employee Handbook
~~C. CalOptima Policy GA.8000: Glossary of Terms~~
~~D.~~C. CalOptima Policy GA.8022: ~~Progressive Discipline~~Performance and Behavior Standards Performance Improvement
D. Supervisor's Guide -Work Performance Behaviors, Alcohol and Drug Impairment Indicators, Department of Transportation
E. Federal Drug-Free Workplace Act of 1988 (41, U.S.C., §701 *et seq.*)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8052	Drug-Free and Alcohol-Free Workplace	Administrative
Revised	02/02/2017	GA.8052	Drug-Free and Alcohol-Free Workplace	Administrative
Revised	TBD	GA.8052	Drug-Free and Alcohol-Free Workplace	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Property	Any property owned, operated or leased by CalOptima, including CalOptima owned or leased vehicles, the administration building at 505 City Parkway West, in the City of Orange, State of California, ~~and~~ the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and ~~including CalOptima owned or leased vehicles.~~the CalOptima satellite office located at the County Community Service Center, 15496 Magnolia Street, Suite 111, in the City of Westminster, State of California. CalOptima Property shall include surrounding ground and parking lots owned, operated, or leased by CalOptima, as well as other leased or rented spaces.
Member	A beneficiary who is enrolled in a CalOptima Program.
Safety Sensitive Employee	A position where the employee has the responsibility for his or her own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Members. This shall include any employee who operates a CalOptima owned or leased motor vehicle.
Termination	The end of the employment relationship.
Under the Influence of Alcohol	An employee with a blood alcohol concentration (BAC) of .04 or above.

Policy:	GA.8052
Title:	**Drug-Free and Alcohol-Free Workplace**
Department:	Human Resources
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	02/01/2014
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines for a drug-free and alcohol-free workplace at CalOptima and CalOptima PACE to further enhance safety in the workplace for all employees, promote employee health, maintain a high level of quality in service to CalOptima's Members, ensure productivity, protect against liability, and promote the public's trust in CalOptima. Substance abuse, including the misuse of both legal and illegal drugs, in the workplace can negatively impact employee performance, employee safety, and/or safety of the public. For the purposes of this Policy, and in accordance with federal law, marijuana and other cannabis products fall under the category of "illegal drugs."

II. POLICY

A. CalOptima has a vital interest in maintaining a safe and productive work environment for its employees, Members, and those who come into contact with CalOptima. To support this interest, CalOptima shall maintain a workplace that is free of alcohol, illegal drugs, and controlled substances and herein discourages alcohol and substance abuse by its employees.

B. The following behavior while on duty or on CalOptima Property are separately, or in combination violations of CalOptima's Drug-Free and Alcohol-Free Workplace Policy:

1. The unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance;

2. Possession or use of alcohol or an illegal or controlled substance, or being under the influence of alcohol or an illegal or controlled substance, while on duty, or on or in CalOptima Property, except where the controlled substance is lawfully prescribed and used consistent with a doctor's authorization;

3. Abuse of a legal drug, or the purchase, sale, manufacture, distribution, dispensation of any legal prescription drug in a manner inconsistent with the law;

4. Operating a CalOptima owned or leased vehicle or conducting CalOptima business in a personal vehicle while under the influence of alcohol, illegal drugs, or controlled substance; and

Back to Agenda Back to Item

5. Distribution, sale, or purchase of alcohol and/or an illegal or controlled substance while on-duty or on or in CalOptima Property.

C. This Policy and each of its rules apply:

1. Whenever an employee is on or in CalOptima Property;

2. During company time (includes breaks, meal periods, and work duties offsite (e.g., representing CalOptima at community functions or meetings, meeting with Members, or providers, etc.));

3. In any vehicle used on company business; and

4. In other circumstances (such as on customer premises, or at business/sales functions) that may adversely affect CalOptima's operations, safety, reputation and/or the administration of this Policy.

D. It is the policy of CalOptima and a condition of employment that an employee be present and able to physically and mentally perform his/her job free from the effects of alcohol, narcotics, depressants, stimulants, hallucinogens, and cannabis, or any other substances which can impair job performance.

E. Violation of this Policy will not be tolerated, and CalOptima shall take appropriate actions, including, but not limited to, corrective action, up to and including termination, to protect, as fully as possible, all CalOptima employees and members of the public. CalOptima may also bring the matter to the attention of appropriate law enforcement authorities and/or professional licensing authorities.

III. PROCEDURE

A. Prohibitions: An employee who violates any one (1) of these prohibitions shall be subject to corrective action, up to and including termination:

1. Alcohol: An employee may not possess, distribute, dispense, sell, use, transfer, offer, or be under the influence of any intoxicating liquor such that the employee's blood alcohol concentration (BAC) is .04, or above, while at work, or on-duty for CalOptima business. Off-duty use of alcohol that adversely affects, or impairs, an employee's job performance, or results in on-duty conduct which adversely affects, or threatens to adversely affect, CalOptima's interest is prohibited.

a. This rule prohibits using any alcohol prior to reporting to work such that the employee's BAC is .04 or above during breaks or meal periods, or in conjunction with any CalOptima activity, except social or business events where the Chief Executive Officer and/or other members of the Executive Staff has/have authorized the moderate consumption of alcoholic beverages.

b. An employee at work or on-duty, for CalOptima business with a BAC level at.04, or above, shall be removed from duty and may be subject to disciplinary action, up to and including termination.

2. Drugs: An employee may not possess, distribute, dispense, sell, use, transfer, offer, share, attempt to sell, or obtain, manufacture, or be under the influence of any illegal drug or controlled substance, or have any trace of illegal drugs or controlled substance present in the

body while at work or on duty for CalOptima business. Therefore, an employee who tests positive for any illegal drug or controlled substance will be deemed to have violated this rule.

a. This rule also prohibits prescription drugs being taken while on duty without a doctor's authorization.

b. Abuse of a legal drug or the purchase, sale, manufacture, distribution, dispensation of any legal prescription drug in a manner inconsistent with the law is also prohibited under this rule.

3. Prescriptions/Over–The-Counter Medications: An employee is responsible for checking the potential side effects of prescription drugs and over-the-counter medications with their doctor or pharmacist before reporting to work, and to immediately let their supervisor know when such use makes it unsafe for them to report to work or do their job.

4. Adulterants: An employee is prohibited from using any substance that is used for the purpose of manipulating the results of a drug test.

B. Pre-Employment Testing: All employees in Safety Sensitive classifications are required to pass a pre-employment urine drug test as a condition of employment in the classification.

C. Random Drug Testing: Effective thirty (30) calendar days after the adoption of this Policy, the following shall apply:

1. All CalOptima employees who provide health care services and personal care services to CalOptima Members may be subject to random drug testing. This shall include any employee who operates a CalOptima owned or leased motor vehicle.

2. All CalOptima employees who have face-to-face interaction in the residence of a Member, or prospective Member, and provide health care services, or personal care services, such as nurses in the field, may be subject to random drug testing.

D. Mandatory Post Traffic Accident Testing: When a CalOptima employee is involved in a work-related traffic accident, CalOptima shall request a drug and/ alcohol test if there is a reasonable suspicion of the involvement of drugs and/or alcohol.

E. Reasonable Suspicion Testing or Reasonable Cause

1. If a supervisor, Human Resources and/or Manager, Environmental Health and Safety suspects an employee is under the influence of drugs and/or alcohol and observes two (2) or more of the following, shall immediately notify the Human Resources Department and submit a completed *Drug And Alcohol Reasonable Suspicion Checklist* form to the Human Resources Department within twenty-four (24) hours:

a. Difficulty walking such as swaying, an unstable gait, staggering, or stumbling, especially when not consistent with the employee's normal behavior;

b. Flushed skin;

c. Bloodshot eyes and/or inability to make eye contact;

d. Slurred speech;

e. Odor of alcohol or drugs on the employee's breath, clothes, or in an area (such as in a vehicle, office, work area, or restroom) immediately controlled or occupied, by the employee;

f. Alcohol, alcohol containers, illegal drugs, or drug paraphernalia in the employee's possession, or in an area controlled or occupied by the employee (such as in a vehicle, office, work area, or restroom);

g. Unexplained or significant deterioration in job performance;

h. Unexplained significant changes in behavior (e.g., lethargy, abusive behavior, repeated disregard of safety rules, or procedures, insubordination, etc.);

i. Unexplained absenteeism or tardiness;

j. Employee admissions regarding drug or alcohol use; and/or

k. Involvement in any work-related accident or near misses.

2. If a Human Resources representative or the Manager of Environmental Health and Safety or the supervisor along with the Human Resources Representative or Manager of Environmental Health and Safety have reasonable suspicion that an employee may be under the influence of or has consumed drugs or alcohol while on-duty or on CalOptima Property, CalOptima may direct the employee to undergo a drug and alcohol test. If the employee refuses to undergo the test, such refusal may result in corrective action, up to and including termination from employment.

3. The supervisor and/or Human Resources representative or the Manager of Environmental Health and Safety will inform the employee about the consequences to the employee if the drug and alcohol test is positive, which shall include corrective action, up to and including termination from employment, and/or required admission to a drug and/or alcohol treatment program.

4. If appropriate, Human Resources representative may assist the employee in making arrangements to be taken home after a drug and/or alcohol test is completed. CalOptima employees who are not relatives of the employee may not provide the transportation themselves.

F. Scope of Tests: All tests shall be conducted by a certified laboratory. Employees may be tested for, but not limited to the following:

1. Alcohol;

2. Amphetamines, or other stimulants;

3. Cannabinoids (THC), such as marijuana and hashish;

4. Cocaine;

5. Opiates, or other narcotics;

6. Phencyclidine; and

7. Barbiturates, or other depressants.

G. Positive Tests: If a positive test result can be explained by the legal use of any substance, an employee may present verification by a licensed medical professional. Any employee who tests positive for drugs that are not prescribed to him or her by their physician will be immediately removed from duty. Additionally, corrective action will be taken which may include:

1. Corrective action, up to and including termination;

2. Referral to a substance abuse professional for assessment and recommendations;

3. Requirement to pass a Return-to-Duty test; or

4. Requirement to sign a Return-to-Work Agreement.

H. Confidentiality: CalOptima shall maintain all drug-testing information in separate confidential records.

I. Employee Assistance Program:

1. CalOptima is committed to helping employees remain productive members of CalOptima's team. CalOptima provides an Employee Assistance Program (EAP) for employees to provide counseling and other services for employees with substance abuse and other personal or emotional problems that can affect work performance. The EAP will treat information obtained regarding an employee during participation in such program or services, as confidential in accordance with Federal and State laws.

2. No employee shall receive corrective action or discriminated against for simply seeking help from the EAP, if such help or request for help is prior to a violation of this Policy.

3. In certain circumstances, CalOptima may insist upon a mandatory referral to CalOptima's EAP as a condition of continued employment.

J. Condition of Continued Employment: If a violation of the Policy has occurred continued employment with CalOptima may be conditioned upon:

1. Entering into and completing a treatment program approved by CalOptima;

2. Signing and complying with a last chance performance agreement; and/or

3. Undergoing random drug and/or alcohol test for a specified period of time.

K. Fit for Duty:

1. CalOptima may require a fit for duty exam by a certified medical practitioner. This exam may be administered along with a drug test to determine if the employee is fit for duty.

L. Duty to Cooperate:

1. As a condition of continued employment, employees are expected to cooperate with the full administration of this Policy. Violation of this Policy includes, but is not limited to:

a. Refusing to participate in testing, submit a sample, or sign required forms;

b. Refusing to cooperate in any way (for example, refusing to courteously and candidly cooperate in any interview or investigation, including any form of untruthfulness, misrepresentation, misleading statements, or omissions);

c. Any form of dishonesty in the testing process or related investigation;

d. Refusing to test again at a time of CalOptima's choosing whenever any test results in a finding of a dilute sample, or reasonable suspicion; and/or

e. Failure to adhere to the conditions of continued employment.

M. Self-Disclosure of Convictions: Employees are required to report any drug and/or alcohol related convictions occurring outside of the workplace to CalOptima within five (5) calendar days of such conviction. Failure to do so is considered a violation of this Policy. This information may subject the employee to corrective action, random testing requirements, referral to the EAP, and/or may be reported to the appropriate licensing authority.

IV. ATTACHMENT(S)

A. Drug and Alcohol Reasonable Suspicion Checklist

V. REFERENCE(S)

A. California Drug-Free Workplace Act of 1990 (California Government Code, §§8350-8351 and 8355-8357)
B. CalOptima Employee Handbook
C. CalOptima Policy GA.8022: Performance and Behavior Standards Performance Improvement
D. Supervisor's Guide -Work Performance Behaviors, Alcohol and Drug Impairment Indicators, Department of Transportation
E. Federal Drug-Free Workplace Act of 1988 (41, U.S.C., §701 *et seq.*)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8052	Drug-Free and Alcohol-Free Workplace	Administrative
Revised	02/02/2017	GA.8052	Drug-Free and Alcohol-Free Workplace	Administrative
Revised	TBD	GA.8052	Drug-Free and Alcohol-Free Workplace	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Property	Any property owned, operated or leased by CalOptima, including CalOptima owned or leased vehicles, the administration building at 505 City Parkway West, in the City of Orange, State of California, the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and the CalOptima satellite office located at the County Community Service Center, 15496 Magnolia Street, Suite 111, in the City of Westminster, State of California. CalOptima Property shall include surrounding ground and parking lots owned, operated, or leased by CalOptima, as well as other leased or rented spaces.
Member	A beneficiary who is enrolled in a CalOptima Program.
Safety Sensitive Employee	A position where the employee has the responsibility for his or her own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Members. This shall include any employee who operates a CalOptima owned or leased motor vehicle.
Termination	The end of the employment relationship.
Under the Influence of Alcohol	An employee with a blood alcohol concentration (BAC) of .04 or above.

DRUG AND ALCOHOL REASONABLE SUSPICION CHECKLIST

GENERAL		
Employee Name:	**Date of Observation:**	**Time of Observation:**
Location:	**Reasonable suspicion of:** ___**Alcohol** ___**Drugs**	**Employee agree to testing?** ___**Yes** ___**No**

When there is reasonable suspicion that an employee is under the influence of drugs and/or alcohol and is unfit for duty, the supervisor or manager observing the behavior, as well as another supervisor/manager as a witness, if possible, must complete the checklist below. Where "Other" is checked, please describe. **Submit the completed form to Human Resources within 24 hours of the incident.**

___*Observation Checklist* (check all observations that are applicable):

Speech:	___Normal	___Incoherent	___Loud	___Silent
	___Slurred	___Whispering	___Disruptive	
	___Rambling	___Slobbering	___Slow	
	___Other: _____			
Standing:	___Normal	___Swaying	____Unable to Stand	
	___Unsteady	___Staggering	____Falling	
	___Other: _____			
Walking:	___Normal	___Stumbling	___Unable to Walk	
	___Unsteady	___Swaying	___Holding On/Reach for Support	
	___Falling	___Staggering		
	___Other: _____			
Demeanor:	___Normal	___Paranoid	___Lack of Coordination	
	___Disoriented/Confused	___Sleepy/Lethargic	___Excited	
	___Argumentative	___Talkative	___Crying	
	___Overly Nervous	___Difficulty Concentrating	___Isolation	____Other
	For each item checked in this box, describe your observations: _____			
Actions:	___Normal	___Hyperactive	___Resisting Communication	
	___Hostile	___Erratic	___Profanity	
	___Threatening	___Drowsy	___Calm	
	___Lethargic	___Other		
	For each item checked in this box, describe your observations: _____			
Eyes:	___Normal	___Closed	___Droopy/Half-closed	
	___Bloodshot/Red	___Dilated Pupils	____Constricted Pupils	
	___Glassy	___Inability of Make Eye Contract		
	___Use of Sunglasses Indoors	___Jerky Movement of Eyes	___Blank Stare	
	___Other _____			
~~Face~~Skin:	___Normal	___Flushed Face/Neck/Head	___Sweaty	
	___Redness/Irritation around nasal area			
	___Other: _____			
Appearance/Clothing:	___Normal	___Unruly/Messy	___Dirty/Stains	
	_____	___Other:		
	___Describe the appearance: _____			

Odor:	___Normal ___ ___ ___Alcohol/drug odor ___ ___ ___Heavy breath spray/cologne ___Glue/Solvent/Paint ___ ___Other: ___
Movements:	___Normal ___Jerky ___Nervous ___Lack of coordination ___Muscle Rigidity ___ Fumbling ___ Slow ___ Hyperactive ___Hand or Finger Tremors ___Other: For each item checked in this box, describe your observations: ___
Miscellaneous:	___Alcohol and/or drugs present in employee's possession or vicinity ___Employee admitted to alcohol and/or drug use or possession ___Unexplained significant deterioration in job performance ___Unexplained absenteeism or tardiness/leaving early ___Repeated disregard for safety and/or of safety rules/procedures ___Amnesia ___Hearing/Seeing things that aren't there ___Coma ___Convulsions ___Other: ___

Other observations/Comments: ___

___

___ ___ ___

Supervisor/Manager Signature Print Name Date & Time

___ ___ ___

Witness Signature Print Name Date & Time

___ ___ ___

Human Resources Reviewer Signature Print Name/Title Date & Time

DRUG AND ALCOHOL REASONABLE SUSPICION CHECKLIST

GENERAL		
Employee Name:	**Date of Observation:**	**Time of Observation:**
Location:	**Reasonable suspicion of:** ___**Alcohol** ___**Drugs**	**Employee agree to testing?** ___**Yes** ___**No**

When there is reasonable suspicion that an employee is under the influence of drugs and/or alcohol and is unfit for duty, the supervisor or manager observing the behavior, as well as another supervisor/manager as a witness, if possible, must complete the checklist below. Where "Other" is checked, please describe. **Submit the completed form to Human Resources within 24 hours of the incident.**

Observation Checklist (check all observations that are applicable):

Speech:	___Normal ___Incoherent ___Loud ___Silent ___Slurred ___Whispering ___Disruptive ___Rambling ___Slobbering ___Slow ___Other: _____
Standing:	___Normal ___Swaying ____Unable to Stand ___Unsteady ___Staggering ____Falling ___Other: _____
Walking:	___Normal ___Stumbling ___Unable to Walk ___Unsteady ___Swaying ___Holding On/Reach for Support ___Falling ___Staggering ___Other: _____
Demeanor:	___Normal ___Paranoid ___Lack of Coordination ___Disoriented/Confused ___Sleepy/Lethargic ___Excited ___Argumentative ___Talkative ___Crying ___Overly Nervous ___Difficulty Concentrating ___Isolation ____Other For each item checked in this box, describe your observations: _____
Actions:	___Normal ___Hyperactive ___Resisting Communication ___Hostile ___Erratic ___Profanity ___Threatening ___Drowsy ___Calm ___Lethargic ___Other For each item checked in this box, describe your observations:_____
Eyes:	___Normal ___Closed ___Droopy/Half-closed ___Bloodshot/Red ___Dilated Pupils ____Constricted Pupils ___Glassy ___Inability of Make Eye Contract ___Use of Sunglasses Indoors ___Jerky Movement of Eyes ___Blank Stare ___Other_____
Skin:	___Normal ___Flushed Face/Neck/Head ___Sweaty ___Redness/Irritation around nasal area ___Other: _____
Appearance/Clothing:	___Normal ___Unruly/Messy ___Dirty/Stains ___Other Describe the appearance: _____

Odor:	___Normal ___Alcohol/drug odor ___Heavy breath spray/cologne ___ Glue/Solvent/Paint ___Other: _____
Movements:	____Normal ____Jerky ____Nervous ___Lack of coordination ___Muscle Rigidity ___Fumbling ____ Slow ____ Hyperactive ___Hand or Finger Tremors ___Other: For each item checked in this box, describe your observations:_____ _____
Miscellaneous:	___Alcohol and/or drugs present in employee's possession or vicinity ___Employee admitted to alcohol and/or drug use or possession ___Unexplained significant deterioration in job performance ___Unexplained absenteeism or tardiness/leaving early ___Repeated disregard for safety and/or of safety rules/procedures ___Amnesia ___Hearing/Seeing things that aren't there ___Coma ___Convulsions ___Other: _____

Other observations/Comments: _____

_____

_____ _____ _____

Supervisor/Manager Signature Print Name Date & Time

_____ _____ _____

Witness Signature Print Name Date & Time

_____ _____ _____

Human Resources Reviewer Signature Print Name/Title Date & Time

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	09/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years;

Back to Agenda Back to Item

and

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 09/03/2020)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative

Action	Date	Policy #	Policy Title	Program(s)
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative

1

GLOSSARY

Not Applicable

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	09/03/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years;

Back to Agenda Back to Item

and

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

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

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

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

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

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

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 09/03/2020)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative

GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

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

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Documentation Specialist (RN)	O	641	$82,576	$107,328	$131,976	
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Community Relations Specialist Sr	K	646	$47,112	$61,360	$75,504	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Manager Sr	O	TBD	$82,576	$107,328	$131,976	New Position
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	654	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
	Deputy Clerk of the Board	M	TBD	$62,400	$81,120	$99,840	New Position
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
*	Director Business Development	P	351	$95,264	$128,752	$162,032	
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480	
*	Director Case Management	Q	318	$114,400	$154,440	$194,480	
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032	
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
*	Director Communications	P	361	$95,264	$128,752	$162,032	
*	Director Community Relations	P	292	$95,264	$128,752	$162,032	
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	Director Contracting	P	184	$95,264	$128,752	$162,032	
*	Director COREC	Q	369	$114,400	$154,440	$194,480	
*	Director Customer Service	P	118	$95,264	$128,752	$162,032	
*	Director Electronic Business	P	358	$95,264	$128,752	$162,032	
*	Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
*	Director Facilities	P	428	$95,264	$128,752	$162,032	
*	Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
*	Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
*	Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
*	Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
*	Director Government Affairs	P	277	$95,264	$128,752	$162,032	
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
*	Director Health Services	Q	328	$114,400	$154,440	$194,480	
*	Director Human Resources	Q	322	$114,400	$154,440	$194,480	
*	Director Information Services	R	547	$137,280	$185,328	$233,376	
*	Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
*	Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
*	Director Network Management	P	125	$95,264	$128,752	$162,032	
*	Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
*	Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
*	Director PACE Program	Q	449	$114,400	$154,440	$194,480	
*	Director Population Health Management	Q	675	$114,400	$154,440	$194,480	
*	Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
*	Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
*	Director Project Management	Q	447	$114,400	$154,440	$194,480	
*	Director Provider Data Quality	Q	655	$114,400	$154,440	$194,480	
*	Director Provider Services	P	597	$95,264	$128,752	$162,032	
*	Director Public Policy	P	459	$95,264	$128,752	$162,032	
*	Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
*	Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
*	Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
*	Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
*	Director Strategic Development	P	121	$95,264	$128,752	$162,032	
*	Director Systems Development	R	169	$137,280	$185,328	$233,376	
*	Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
*	Director Vendor Management	P	TBD	$95,264	$128,752	$162,032	New Position
	Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
	Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
	EDI Project Manager	O	403	$82,576	$107,328	$131,976	
	Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
	Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
	Executive Adminstrative Services Manager	M	661	$62,400	$81,120	$99,840	
	Executive Assistant	K	339	$47,112	$61,360	$75,504	
	Executive Assistant to CEO	L	TBD	$54,288	$70,512	$86,736	
**	Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
**	Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
**	Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
**	Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
**	Executive Director Operations	S	276	$164,736	$222,352	$280,072	
**	Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
**	Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
**	Executive Director Quality & Population Health Management	S	676	$164,736	$222,352	$280,072	
**	Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
	Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
	Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
Financial Analyst	L	51	$54,288	$70,512	$86,736	
Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
Graphic Designer	M	387	$62,400	$81,120	$99,840	
Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
Health Coach	M	556	$62,400	$81,120	$99,840	
Health Educator	K	47	$47,112	$61,360	$75,504	
Health Educator Sr	L	355	$54,288	$70,512	$86,736	
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
Help Desk Technician	J	571	$40,976	$53,352	$65,624	
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Compensation Specialist Sr	N	663	$71,760	$93,184	$114,712	
HR Coordinator	J	316	$40,976	$53,352	$65,624	
HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
LVN Specialist	M	TBD	$62,400	$81,120	$99,840	New Position
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Marketing & Outreach	O	TBD	$82,576	$107,328	$131,976	New Position
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
Manager MSSP	O	393	$82,576	$107,328	$131,976	
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
Manager PACE Center	O	432	$82,576	$107,328	$131,976	
Manager Population Health Management	O	674	$82,576	$107,328	$131,976	
Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
Manager Project Management	O	532	$82,576	$107,328	$131,976	
Manager Provider Data Management Services	N	653	$71,760	$93,184	$114,712	
Manager Provider Network	O	191	$82,576	$107,328	$131,976	
Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
Manager Provider Services	O	656	$82,576	$107,328	$131,976	
Manager Purchasing	N	275	$71,760	$93,184	$114,712	
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Payroll Specialist Sr	K	TBD	$47,112	$61,360	$75,504	New Position
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	E	485	$25,272	$31,720	$37,960	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	J	525	$37,128	$46,384	$55,640	
	Personal Care Coordinator Sr	J	TBD	$40,976	$53,352	$65,624	New Position
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Privacy Officer	P	648	$95,264	$128,752	$162,032	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recreational Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Dietitian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
	Social Worker Sr	L	TBD	$54,288	$70,512	$86,736	New Position
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
*	Sr Director Regulatory Affairs and Compliance	R	658	$137,280	$185,328	$233,376	
	Sr Manager Financial Analysis	P	660	$95,264	$128,752	$162,032	
	Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
	Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032	
	Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480	
	Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976	
	Staff Attorney	P	195	$95,264	$128,752	$162,032	
	Staff Attorney Sr	Q	TBD	$114,400	$154,440	$194,480	New Position
	Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
	Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
	Supervisor Behavioral Health	N	659	$71,760	$93,184	$114,712	
	Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
	Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
	Supervisor Claims	K	219	$47,112	$61,360	$75,504	
	Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
	Supervisor Credentialing	L	671	$54,288	$70,512	$86,736	
	Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
	Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
	Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
	Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	

CalOptima - Annual Base Salary Schedule - Revised ~~August 1, 2019~~ September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor Member Outreach and Education	M	TBD	$62,400	$81,120	$99,840	New Position
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor Nursing Services (PACE)	N	662	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Population Health Management	N	673	$71,760	$93,184	$114,712	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

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

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

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

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

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

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Claims Examiner	H	9	$33,696	$42,224	$50,648
Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624
Claims Examiner Sr	I	20	$37,128	$46,384	$55,640
Claims QA Analyst	I	28	$37,128	$46,384	$55,640
Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624
Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640
Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640
Clerk of the Board	O	59	$82,576	$107,328	$131,976
Clinical Auditor	M	567	$62,400	$81,120	$99,840
Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712
Clinical Documentation Specialist (RN)	O	641	$82,576	$107,328	$131,976
Clinical Pharmacist	P	297	$95,264	$128,752	$162,032
Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840
Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840
Communications Specialist	J	188	$40,976	$53,352	$65,624
Community Partner	K	575	$47,112	$61,360	$75,504
Community Partner Sr	L	612	$54,288	$70,512	$86,736
Community Relations Specialist	J	288	$40,976	$53,352	$65,624
Community Relations Specialist Sr	K	646	$47,112	$61,360	$75,504
Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504
Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736
Contract Administrator	M	385	$62,400	$81,120	$99,840
Contracts Manager	N	207	$71,760	$93,184	$114,712
Contracts Manager Sr	O	TBD	$82,576	$107,328	$131,976
Contracts Specialist	K	257	$47,112	$61,360	$75,504
Contracts Specialist Int	L	469	$54,288	$70,512	$86,736
Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840
* Controller	Q	464	$114,400	$154,440	$194,480
Credentialing Coordinator	J	41	$40,976	$53,352	$65,624
Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624
Customer Service Coordinator	J	182	$40,976	$53,352	$65,624
Customer Service Rep	H	5	$33,696	$42,224	$50,648
Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624
Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640
Data Analyst	K	337	$47,112	$61,360	$75,504
Data Analyst Int	L	341	$54,288	$70,512	$86,736
Data Analyst Sr	M	342	$62,400	$81,120	$99,840
Data and Reporting Analyst - Lead	O	654	$82,576	$107,328	$131,976
Data Entry Tech	F	3	$27,872	$34,840	$41,808
Data Warehouse Architect	O	363	$82,576	$107,328	$131,976
Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976
Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976
Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712
Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976
Database Administrator	M	90	$62,400	$81,120	$99,840
Database Administrator Sr	O	179	$82,576	$107,328	$131,976

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024
	Deputy Clerk of the Board	M	TBD	$62,400	$81,120	$99,840
*	Director Accounting	P	122	$95,264	$128,752	$162,032
*	Director Applications Management	R	170	$137,280	$185,328	$233,376
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480
*	Director Business Development	P	351	$95,264	$128,752	$162,032
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480
*	Director Case Management	Q	318	$114,400	$154,440	$194,480
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032
*	Director Communications	P	361	$95,264	$128,752	$162,032
*	Director Community Relations	P	292	$95,264	$128,752	$162,032
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480
*	Director Contracting	P	184	$95,264	$128,752	$162,032
*	Director COREC	Q	369	$114,400	$154,440	$194,480
*	Director Customer Service	P	118	$95,264	$128,752	$162,032
*	Director Electronic Business	P	358	$95,264	$128,752	$162,032
*	Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480
*	Director Facilities	P	428	$95,264	$128,752	$162,032
*	Director Finance & Procurement	P	157	$95,264	$128,752	$162,032
*	Director Financial Analysis	R	374	$137,280	$185,328	$233,376
*	Director Financial Compliance	P	460	$95,264	$128,752	$162,032
*	Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480
*	Director Government Affairs	P	277	$95,264	$128,752	$162,032
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032
*	Director Health Services	Q	328	$114,400	$154,440	$194,480
*	Director Human Resources	Q	322	$114,400	$154,440	$194,480
*	Director Information Services	R	547	$137,280	$185,328	$233,376
*	Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480
*	Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032
*	Director Network Management	P	125	$95,264	$128,752	$162,032
*	Director OneCare Operations	P	425	$95,264	$128,752	$162,032
*	Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032
*	Director PACE Program	Q	449	$114,400	$154,440	$194,480
*	Director Population Health Management	Q	675	$114,400	$154,440	$194,480
*	Director Process Excellence	Q	447	$114,400	$154,440	$194,480
*	Director Program Implementation	Q	489	$114,400	$154,440	$194,480
*	Director Project Management	Q	447	$114,400	$154,440	$194,480
*	Director Provider Data Quality	Q	655	$114,400	$154,440	$194,480
*	Director Provider Services	P	597	$95,264	$128,752	$162,032
*	Director Public Policy	P	459	$95,264	$128,752	$162,032

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
* Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480
* Director Quality Analytics	Q	591	$114,400	$154,440	$194,480
* Director Quality Improvement	Q	172	$114,400	$154,440	$194,480
* Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480
* Director Strategic Development	P	121	$95,264	$128,752	$162,032
* Director Systems Development	R	169	$137,280	$185,328	$233,376
* Director Utilization Management	Q	265	$114,400	$154,440	$194,480
* Director Vendor Management	P	TBD	$95,264	$128,752	$162,032
Disease Management Coordinator	M	70	$62,400	$81,120	$99,840
Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840
EDI Project Manager	O	403	$82,576	$107,328	$131,976
Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504
Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032
Executive Adminstrative Services Manager	M	661	$62,400	$81,120	$99,840
Executive Assistant	K	339	$47,112	$61,360	$75,504
Executive Assistant to CEO	L	TBD	$54,288	$70,512	$86,736
** Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072
** Executive Director Compliance	S	493	$164,736	$222,352	$280,072
** Executive Director Human Resources	S	494	$164,736	$222,352	$280,072
** Executive Director Network Operations	S	632	$164,736	$222,352	$280,072
** Executive Director Operations	S	276	$164,736	$222,352	$280,072
** Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072
** Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072
** Executive Director Quality & Population Health Management	S	676	$164,736	$222,352	$280,072
** Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072
Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624
Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624
Facilities Coordinator	J	438	$40,976	$53,352	$65,624
Financial Analyst	L	51	$54,288	$70,512	$86,736
Financial Analyst Sr	M	84	$62,400	$81,120	$99,840
Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736
Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840
Graphic Designer	M	387	$62,400	$81,120	$99,840
Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712
Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624
Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736
Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504
Health Coach	M	556	$62,400	$81,120	$99,840
Health Educator	K	47	$47,112	$61,360	$75,504
Health Educator Sr	L	355	$54,288	$70,512	$86,736
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840
Help Desk Technician	J	571	$40,976	$53,352	$65,624
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
HR Assistant	I	181	$37,128	$46,384	$55,640
HR Business Partner	M	584	$62,400	$81,120	$99,840
HR Compensation Specialist Sr	N	663	$71,760	$93,184	$114,712
HR Coordinator	J	316	$40,976	$53,352	$65,624
HR Representative	L	278	$54,288	$70,512	$86,736
HR Representative Sr	M	350	$62,400	$81,120	$99,840
HR Specialist	K	505	$47,112	$61,360	$75,504
HR Specialist Sr	L	608	$54,288	$70,512	$86,736
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736
Intern	E	237	$25,272	$31,720	$37,960
Investigator Sr	L	553	$54,288	$70,512	$86,736
IS Coordinator	J	365	$40,976	$53,352	$65,624
IS Project Manager	O	424	$82,576	$107,328	$131,976
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032
IS Project Specialist	M	549	$62,400	$81,120	$99,840
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712
Kitchen Assistant	E	585	$25,272	$31,720	$37,960
Legislative Program Manager	N	330	$71,760	$93,184	$114,712
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840
LVN (PACE)	M	533	$62,400	$81,120	$99,840
LVN Specialist	M	TBD	$62,400	$81,120	$99,840
Mailroom Clerk	E	1	$25,272	$31,720	$37,960
Manager Accounting	N	98	$71,760	$93,184	$114,712
Manager Actuary	P	453	$95,264	$128,752	$162,032
Manager Applications Management	P	271	$95,264	$128,752	$162,032
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976
Manager Business Integration	O	544	$82,576	$107,328	$131,976
Manager Case Management	O	270	$82,576	$107,328	$131,976
Manager Claims	N	92	$71,760	$93,184	$114,712
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480
Manager Coding Quality	N	382	$71,760	$93,184	$114,712
Manager Communications	N	398	$71,760	$93,184	$114,712
Manager Community Relations	M	384	$62,400	$81,120	$99,840
Manager Contracting	O	329	$82,576	$107,328	$131,976
Manager Creative Branding	N	430	$71,760	$93,184	$114,712
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712
Manager Customer Service	N	94	$71,760	$93,184	$114,712
Manager Decision Support	O	454	$82,576	$107,328	$131,976
Manager Electronic Business	O	422	$82,576	$107,328	$131,976

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Manager Employment Services	N	420	$71,760	$93,184	$114,712
Manager Encounters	N	516	$71,760	$93,184	$114,712
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712
Manager Facilities	N	209	$71,760	$93,184	$114,712
Manager Finance	N	148	$71,760	$93,184	$114,712
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976
Manager Government Affairs	N	437	$71,760	$93,184	$114,712
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712
Manager Health Education	N	173	$71,760	$93,184	$114,712
Manager HEDIS	O	427	$82,576	$107,328	$131,976
Manager Human Resources	O	526	$82,576	$107,328	$131,976
Manager Information Services	P	560	$95,264	$128,752	$162,032
Manager Information Technology	P	110	$95,264	$128,752	$162,032
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976
Manager Marketing & Outreach	O	TBD	$82,576	$107,328	$131,976
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976
Manager MSSP	O	393	$82,576	$107,328	$131,976
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712
Manager PACE Center	O	432	$82,576	$107,328	$131,976
Manager Population Health Management	O	674	$82,576	$107,328	$131,976
Manager Process Excellence	O	622	$82,576	$107,328	$131,976
Manager Program Implementation	O	488	$82,576	$107,328	$131,976
Manager Project Management	O	532	$82,576	$107,328	$131,976
Manager Provider Data Management Services	N	653	$71,760	$93,184	$114,712
Manager Provider Network	O	191	$82,576	$107,328	$131,976
Manager Provider Relations	N	171	$71,760	$93,184	$114,712
Manager Provider Services	O	656	$82,576	$107,328	$131,976
Manager Purchasing	N	275	$71,760	$93,184	$114,712
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976
Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976
Manager Strategic Development	O	603	$82,576	$107,328	$131,976
Manager Strategic Operations	N	446	$71,760	$93,184	$114,712
Manager Systems Development	P	515	$95,264	$128,752	$162,032

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

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	Manager Utilization Management	O	250	$82,576	$107,328	$131,976
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624
	Medical Assistant	H	535	$33,696	$42,224	$50,648
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648
	Medical Case Manager	N	72	$71,760	$93,184	$114,712
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736
*	Medical Director	S	306	$164,736	$222,352	$280,072
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032
	Occupational Therapist	N	531	$71,760	$93,184	$114,712
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840
	Office Clerk	C	335	$21,008	$26,208	$31,408
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624
	Outreach Specialist	I	218	$37,128	$46,384	$55,640
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504
	Payroll Specialist	J	554	$40,976	$53,352	$65,624
	Payroll Specialist Sr	K	TBD	$47,112	$61,360	$75,504
	Performance Analyst	L	538	$54,288	$70,512	$86,736
	Personal Care Attendant	E	485	$25,272	$31,720	$37,960
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640
	Personal Care Coordinator Sr	J	TBD	$40,976	$53,352	$65,624
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504
	Physical Therapist	N	530	$71,760	$93,184	$114,712
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976
	Privacy Manager	N	536	$71,760	$93,184	$114,712
	Privacy Officer	P	648	$95,264	$128,752	$162,032
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976
	Program Assistant	I	24	$37,128	$46,384	$55,640
	Program Coordinator	I	284	$37,128	$46,384	$55,640
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840
	Program Manager	M	421	$62,400	$81,120	$99,840
	Program Manager Sr	O	594	$82,576	$107,328	$131,976
	Program Specialist	J	36	$40,976	$53,352	$65,624

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Program Specialist Int	K	61	$47,112	$61,360	$75,504
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840
	Programmer	L	43	$54,288	$70,512	$86,736
	Programmer Int	N	74	$71,760	$93,184	$114,712
	Programmer Sr	O	80	$82,576	$107,328	$131,976
	Project Manager	M	81	$62,400	$81,120	$99,840
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840
	Project Manager Sr	O	105	$82,576	$107,328	$131,976
	Project Specialist	K	291	$47,112	$61,360	$75,504
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736
	Projects Analyst	K	254	$47,112	$61,360	$75,504
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736
	Publications Coordinator	J	293	$40,976	$53,352	$65,624
	QA Analyst	L	486	$54,288	$70,512	$86,736
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840
	Receptionist	F	140	$27,872	$34,840	$41,808
	Recreational Therapist	L	487	$54,288	$70,512	$86,736
	Recruiter	L	406	$54,288	$70,512	$86,736
	Recruiter Sr	M	497	$62,400	$81,120	$99,840
	Registered Dietitian	L	57	$54,288	$70,512	$86,736
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840
	RN (PACE)	N	480	$71,760	$93,184	$114,712
	Security Analyst Int	N	534	$71,760	$93,184	$114,712
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976
	Security Officer	F	311	$27,872	$34,840	$41,808
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976
	Social Worker	K	463	$47,112	$61,360	$75,504
	Social Worker Sr	L	TBD	$54,288	$70,512	$86,736
*	Special Counsel	R	317	$137,280	$185,328	$233,376
*	Sr Director Regulatory Affairs and Compliance	R	658	$137,280	$185,328	$233,376
	Sr Manager Financial Analysis	P	660	$95,264	$128,752	$162,032
	Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032
Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480
Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976
Staff Attorney	P	195	$95,264	$128,752	$162,032
Staff Attorney Sr	Q	TBD	$114,400	$154,440	$194,480
Supervisor Accounting	M	434	$62,400	$81,120	$99,840
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712
Supervisor Behavioral Health	N	659	$71,760	$93,184	$114,712
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840
Supervisor Case Management	N	86	$71,760	$93,184	$114,712
Supervisor Claims	K	219	$47,112	$61,360	$75,504
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840
Supervisor Credentialing	L	671	$54,288	$70,512	$86,736
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504
Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840
Supervisor Encounters	L	253	$54,288	$70,512	$86,736
Supervisor Facilities	L	162	$54,288	$70,512	$86,736
Supervisor Finance	N	419	$71,760	$93,184	$114,712
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840
Supervisor Health Education	M	381	$62,400	$81,120	$99,840
Supervisor Information Services	N	457	$71,760	$93,184	$114,712
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712
Supervisor Member Outreach and Education	M	TBD	$62,400	$81,120	$99,840
Supervisor MSSP	N	348	$71,760	$93,184	$114,712
Supervisor Nursing Services (PACE)	N	662	$71,760	$93,184	$114,712
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504
Supervisor Payroll	M	517	$62,400	$81,120	$99,840
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032
Supervisor Population Health Management	N	673	$71,760	$93,184	$114,712
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504
Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712
Systems Manager	N	512	$71,760	$93,184	$114,712
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504
Technical Analyst Int	L	64	$54,288	$70,512	$86,736

CalOptima - Annual Base Salary Schedule - Revised September 3, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840
Technical Writer	L	247	$54,288	$70,512	$86,736
Technical Writer Sr	M	470	$62,400	$81,120	$99,840
Therapy Aide	J	521	$40,976	$53,352	$65,624
Training Administrator	L	621	$54,288	$70,512	$86,736
Training Program Coordinator	K	471	$47,112	$61,360	$75,504
Translation Specialist	G	241	$30,576	$38,272	$45,968
Web Architect	O	366	$82,576	$107,328	$131,976

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

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

Summary of Changes to Salary Schedule

For September 2020 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Accounting Clerk Sr.	N/A	J	This new position is a step progression responsible for participating in the general accounting functions and coordinate work with Accounting and other departments.	N/A	September 2020
Assistant Director	N/A	O	This new position provides vision and leadership to department employees to ensure high quality and responsive service to members and providers.	N/A	September 2020
Contracts Manager Sr	N/A	O	This new position is a step progression responsible for the negotiation and implementation of new and/or renewal of provider contracts. The incumbent will be responsible for managing and monitoring contractual relationships with existing CalOptima network providers.	N/A	September 2020
Deputy Clerk of the Board	N/A	M	This new position is responsible for overseeing and managing staff and the effective operations of everything that flows through the Clerk of the Board office.	N/A	September 2020

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Director Vendor Management	N/A	P	This new position is responsible for leadership and direction for the development and management of CalOptima's purchasing functions and ensures compliance with CalOptima's Board-approved procurement policy. This position supervises buying staff and interacts with outside vendors and CalOptima management and staff.	N/A	September 2020
LVN Specialist	N/A	M	This new position functions under the direction of a Registered Nurse and within regulatory practice. The Licensed Vocational Nurse (LVN) provides direct nursing care to PACE participants by performing prescribed medical treatments, providing nursing observations, and assisting the registered nurse (RN) in educating participants and their families on care techniques and other health measures.	N/A	September 2020
Manager Marketing & Outreach	N/A	O	This new position is responsible for executing all strategies to maximize member outreach and through various community activities. This will include implementation of a member outreach and retention program. The primary responsibility of this position is to develop and maintain strong relationships between CalOptima, current and potential members, and providers throughout the county.	N/A	September 2020

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Payroll Specialist Sr	N/A	K	This new position is a step progression and will be responsible for assisting the Payroll Manager in all aspects of the timely and accurate processing of bi-weekly, multi-state payroll and year-end payroll related issues for CalOptima. The Payroll Specialist Sr will act as a liaison between the Human Resources and Accounting departments for payroll related issues, generating the required ad-hoc, bi-weekly, monthly and quarterly reports.	N/A	September 2020
Personal Care Coordinator Sr	N/A	J	This new position is a step progression for those in the role of acting as the members point of contact with CalOptima and collaborating with Health Networks to ensure timely communication of member's clinical information.	N/A	September 2020
Social Worker Sr	N/A	L	This new position is a step progression as part of the case management team and acts as the primary contact for Social Services. The Social Worker Sr may complete assessments and use this information to route high risk members to complex case managers. . The Social Worker Sr acts as a resource for case managers, health networks and community partners to address medical, behavioral, and psychosocial concerns.	N/A	September 2020

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Staff Attorney Sr	N/A	Q	This new position is a step progression, performing a variety of professional and specialized legal work of greater complexity and level of difficulty than that assigned to lower level staff attorneys. The Staff Attorney, Sr position works within general instructions and guidelines, exercising discretion and independent judgment in the performance of duties.	N/A	September 2020
Supervisor Member Outreach and Education	N/A	M	This new position is responsible for oversight of the daily operations of the assigned team. Provides guidance to staff to address and resolve operational issues.	N/A	September 2020

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
6. Consider Approval of Proposed Revisions to CalOptima's Customer Service Policies and Procedures

Contact
Belinda Abeyta, Executive Director, Operations (714) 246-8400

Recommended Actions
Approve modification of the following Operations policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. AA.1220: Member Billing
2. DD.2006: Enrollment In/ Eligibility with CalOptima

Background/Discussion
CalOptima staff regularly reviews the organization's Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contracts obligations, and laws as well as CalOptima operations.

Below is information regarding Operations policies that require modification:

1. ***Policy AA.1220: Member Billing*** defines the criteria by which CalOptima enrollees may or may not be billed for health care services. CalOptima staff recommends revising the policy to ensure alignment with current operational processes and regulatory requirements. Revisions include modifications to definitions, adding a reference to Customer Service policy AA.1230: *Member Reimbursement for Covered Services, Excluding Pharmacy Services* and removing references to Claims policies FF.2005: *Conlan, Member Reimbursement* and FF.2007: *Reporting of Potential Third Party Liability* as these policies are no longer applicable to policy AA.2012:*Member Billing* as they are related to reimbursement rather than to the billing of a Member.

2. ***Policy DD.2006: Enrollment In/ Eligibility with CalOptima*** defines the criteria by which CalOptima enrolls a Member in CalOptima Direct. CalOptima staff recommends revising the policy to ensure its alignment with current operational processes and regulatory requirements. Proposed revisions include modifications to definitions and the removal of references to Members residing at the Fairview Developmental Center from the list of mandatory CalOptima Direct Administrative (COD-A) enrollees due to the Fairview Development Center's closure on January 1, 2020.

Fiscal Impact
The recommended action to revise CalOptima Policies DD.2006 and AA.1220 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

Back to Agenda

Rational for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable requirements, staff recommends that the board approve and adopt the proposed updates to the presented CalOptima policies and procedures. The updated policies and procedures will supersede the prior versions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Policy AA.1220: Member Billing
2. CalOptima Policy DD.2006: Enrollment In/ Eligibility with CalOptima

/s/ Richard Sanchez — **Authorized Signature**

08/26/2020 — **Date**

Back to Agenda

Policy ~~#:~~:	AA.1220
Title:	**Member Billing**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	08/01/2010
~~Last Review Date:~~	~~10/01/17~~
~~Last~~ Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy details the circumstances under which a Member may and may not be billed for health care services.

II. POLICY

A. Except as specified in Section II.C. of this policy, in no event, including but not limited to non-payment by CalOptima or a Health Network, CalOptima's or a Health Network's insolvency, or breach of a Contract for Health Care Services, shall a Health Network, Provider, Subcontractor, or Affiliate bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, the County of Orange, a Member, or the Member's representative for CalOptima Covered Services rendered to a Member.

B. A Provider who accepts a Member as a patient shall accept payment from CalOptima or a Health Network for CalOptima Covered Services as payment in full.

C. A Member may be billed under the following circumstances:

1. Services that are not Covered Services and are offered at a charge. CalOptima shall obtain approval from the Department of Health Care Services (DHCS) if CalOptima provides services that are not Covered Services at a charge to Members. CalOptima shall notify Members of the scope of the additional services and applicable charges:

   a. During the enrollment process;

   b. Any time the scope of services is changed; and

   c. Prior to rendering such service.

2. Non-Covered Services. A Provider may bill a Member for Non-Covered Services if:

   a. The Member agrees to the fees in writing prior to the actual delivery of Non-Covered Services,

   b. A copy of such agreement is given to the Member and placed in the ~~Member's~~Member's Medical Record; and/or

c. Services are rendered by a Provider who is not registered with Medi-Cal.

D. A Provider shall verify a CalOptima Medi-Cal Member's eligibility prior to rendering Covered Services in accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification, or through the Automated Eligibility Verification System.

E. A Provider shall obtain appropriate prior authorization for Covered Services, as appropriate, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Health Network's prior authorization procedures.

F. This policy shall survive the termination of a Contract for Health Care Services for those Covered Services rendered prior to the termination of ~~this~~the Contract, regardless of the cause-giving rise to termination.

G. CalOptima shall notify Members of the circumstances under which a Member may be required to pay for health care services in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member Handbook Requirements.

H. CalOptima shall notify Health Networks and Providers of prohibition of Member billing during the contracting process.

I. Sanctions

1. In the event of a violation of this policy, CalOptima shall take appropriate action against a Health Network or Provider, including but not limited to, require repayment of any amounts collected and appropriate Sanctions in accordance with CalOptima Policy HH.2002Δ: Sanctions.

2. If a Health Network or Provider refuses to cease billing or demanding payment from a Member, CalOptima may report the Health Network or Provider's actions to DHCS or ~~other~~another regulatory agency, as necessary.

III. PROCEDURE

A. A Provider shall not bill, seek reimbursement, or attempt to collect payment from a Member or the Member's representative when the Provider is in receipt of proof of the Member's Medi-Cal eligibility. This may include, but is not limited to:

1. Covered Services;

2. Covered Services provided during a period of ~~retroactive eligibility~~Retroactive Eligibility when the Provider has proof of the beneficiary's retroactive Medi-Cal eligibility;

3. Covered Services once a Medi-Cal beneficiary meets his or her Share of Cost and becomes a Member;

4. Copayment, coinsurance, deductible, or other cost sharing required under a Member's Other Health Coverage (OHC);

5. Pending or disputed claims;

6. Fees for missed, broken, canceled, or same day appointments;

7. Fees for completing paperwork or forms related to the delivery of medical care, including but not limited to:

   a. Immunization cards;

   b. WIC referral forms;

   c. Sports physical forms, or history of physical forms that are required by a school;

   d. Medical forms for Department of Motor Vehicles (DMV) requirements;

   e. Disability forms;

   ~~f. PM160 Well Child Visit form;~~

   ~~g.~~f. Forms related to Medi-Cal eligibility; and

   ~~h.~~g. Lead Testing questionnaire.

~~8. A Provider shall report potential third-party liability pursuant to policy FF.2007: Reporting of Potential Third Party Liability.~~

~~9.~~8. Other fees incurred during the course of providing Covered Services to a CalOptima Medi-Cal Member.

B. If a Member is required to pay a copayment, coinsurance, deductible, or other cost sharing under his or her OHC, the Provider shall bill the cost sharing amount as follows: CalOptima for a CalOptima Direct Member, or the Member's Health Network for a Health Network Member.

C. A Member may be billed under the circumstances outlined in section II.C. of this policy.

D. Payment for services during a period of ~~retroactive eligibility~~Retroactive Eligibility. If a Provider collected payment for Covered Services rendered to a Member during a period of ~~retroactive eligibility~~Retroactive Eligibility, the Provider shall reimburse the Member ~~in accordance with~~and bill CalOptima ~~Policy FF.2005: Conlan, Member Reimbursement.~~.

~~E. Actions against a Provider billing a Member~~

~~1.~~ If CalOptima becomes aware that a Provider is demanding payment from a Member for Covered Service, CalOptima shall ~~send written notice to the Provider~~manage such instances in accordance with ~~the following information:~~

~~a. The Provider is required to cease all further demands or collection against the Member;~~

~~F.~~E. ~~To contact~~Section II.I of this policy and CalOptima ~~or the Member's Health Network for claims submission procedures;~~ Policy AA.1230: Member Reimbursement for Covered Services, Excluding Pharmacy Services.

IV. ATTACHMENT(S)

A. Template Letter to Provider Regarding Health Network Member Billing Prohibition
B. Template letter to Provider Regarding COD/CCN Member Billing Prohibition

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Care Services
C. CalOptima Policy AA.1230: Member Reimbursement for Covered Services, Excluding Pharmacy Services
~~C.~~D. CalOptima Policy DD.2003: Member Identification and Eligibility Verification
~~D.~~E. CalOptima Policy DD.2005: Member Handbook Requirements.
~~E. CalOptima Policy FF.2005: Conlan, Member Reimbursement~~
~~F. CalOptima Policy FF.2007: Reporting of Potential Third Party Liability~~
~~G.~~F. CalOptima Policy HH.2002Δ: Sanctions
~~H.~~G. Title 22, California Code of Regulations (CCR), §§ 51002, 53220, 53222, and 53210(d)
~~I.~~H. Title 42, Code of Federal Regulation (CFR), §447.15

~~IV.~~VI. REGULATORY AGENCY APPROVAL

~~07/14/2010:~~ ~~Date~~	~~Regulatory Agency~~ ~~Department of Health Care Services~~
07/14/2010	Department of Health Care Services (DHCS)

~~V.~~VII. BOARD ACTION

None to Date

~~VI.~~VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program ~~of Business~~
Effective	08/01/2010	AA.1220	Member Billing	Medi-Cal
Revised	09/01/2016	AA.1220	Member Billing	Medi-Cal
Revised	10/01/2017	AA.1220	Member Billing	Medi-Cal
Revised		AA.1220	Member Billing	Medi-Cal

~~VII.~~IX. GLOSSARY

Term	Definition
Affiliate	For the purposes of this policy, means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with CalOptima and that provides service to, or receives services from, CalOptima.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22~~.,~~ CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Covered Services	Medical services rendered by a non-Medi-Cal ~~provider~~Provider; or Medical services in the following categories of services for which:

Term	Definition
	1. An authorization request must be submitted and approved before CalOptima will pay; or 2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima because the service is not considered medically necessary.
ProviderOther Health Coverage (OHC)	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. The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Provider	For the purpose of this policy, a person or institution that furnishes Covered Services to Members.
Retroactive Eligibility	Eligibility for Medi-Cal and the CalOptima program established retrospectively by the County of Orange Social Services Agency.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.

1

Policy:	AA.1220
Title:	**Member Billing**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	08/01/2010
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy details the circumstances under which a Member may and may not be billed for health care services.

II. POLICY

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B. A Provider who accepts a Member as a patient shall accept payment from CalOptima or a Health Network for CalOptima Covered Services as payment in full.

C. A Member may be billed under the following circumstances:

1. Services that are not Covered Services and are offered at a charge. CalOptima shall obtain approval from the Department of Health Care Services (DHCS) if CalOptima provides services that are not Covered Services at a charge to Members. CalOptima shall notify Members of the scope of the additional services and applicable charges:

   a. During the enrollment process;

   b. Any time the scope of services is changed; and

   c. Prior to rendering such service.

2. Non-Covered Services. A Provider may bill a Member for Non-Covered Services if:

   a. The Member agrees to the fees in writing prior to the actual delivery of Non-Covered Services,

   b. A copy of such agreement is given to the Member and placed in the Member's Medical Record; and/or

Back to Agenda Back to Item

c. Services are rendered by a Provider who is not registered with Medi-Cal.

D. A Provider shall verify a CalOptima Medi-Cal Member's eligibility prior to rendering Covered Services in accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification, or through the Automated Eligibility Verification System.

E. A Provider shall obtain appropriate prior authorization for Covered Services, as appropriate, in accordance with CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, or the Health Network's prior authorization procedures.

F. This policy shall survive the termination of a Contract for Health Care Services for those Covered Services rendered prior to the termination of the Contract, regardless of the cause-giving rise to termination.

G. CalOptima shall notify Members of the circumstances under which a Member may be required to pay for health care services in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member Handbook Requirements.

H. CalOptima shall notify Health Networks and Providers of prohibition of Member billing during the contracting process.

I. Sanctions

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2. If a Health Network or Provider refuses to cease billing or demanding payment from a Member, CalOptima may report the Health Network or Provider's actions to DHCS or another regulatory agency, as necessary.

III. PROCEDURE

A. A Provider shall not bill, seek reimbursement, or attempt to collect payment from a Member or the Member's representative when the Provider is in receipt of proof of the Member's Medi-Cal eligibility. This may include, but is not limited to:

1. Covered Services;

2. Covered Services provided during a period of Retroactive Eligibility when the Provider has proof of the beneficiary's retroactive Medi-Cal eligibility;

3. Covered Services once a Medi-Cal beneficiary meets his or her Share of Cost and becomes a Member;

4. Copayment, coinsurance, deductible, or other cost sharing required under a Member's Other Health Coverage (OHC);

5. Pending or disputed claims;

6. Fees for missed, broken, canceled, or same day appointments;

7. Fees for completing paperwork or forms related to the delivery of medical care, including but not limited to:

   a. Immunization cards;

   b. WIC referral forms;

   c. Sports physical forms, or history of physical forms that are required by a school;

   d. Medical forms for Department of Motor Vehicles (DMV) requirements;

   e. Disability forms;

   f. Forms related to Medi-Cal eligibility; and

   g. Lead Testing questionnaire.

8. Other fees incurred during the course of providing Covered Services to a CalOptima Medi-Cal Member.

B. If a Member is required to pay a copayment, coinsurance, deductible, or other cost sharing under his or her OHC, the Provider shall bill the cost sharing amount as follows: CalOptima for a CalOptima Direct Member, or the Member's Health Network for a Health Network Member.

C. A Member may be billed under the circumstances outlined in section II.C. of this policy.

D. Payment for services during a period of Retroactive Eligibility. If a Provider collected payment for Covered Services rendered to a Member during a period of Retroactive Eligibility, the Provider shall reimburse the Member and bill CalOptima.

E. If CalOptima becomes aware that a Provider is demanding payment from a Member for Covered Service, CalOptima shall manage such instances in accordance with Section II.I of this policy and CalOptima Policy AA.1230: Member Reimbursement for Covered Services, Excluding Pharmacy Services.

IV. ATTACHMENT(S)

A. Template Letter to Provider Regarding Health Network Member Billing Prohibition
B. Template letter to Provider Regarding COD/CCN Member Billing Prohibition

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Care Services
C. CalOptima Policy AA.1230: Member Reimbursement for Covered Services, Excluding Pharmacy Services
D. CalOptima Policy DD.2003: Member Identification and Eligibility Verification
E. CalOptima Policy DD.2005: Member Handbook Requirements.
F. CalOptima Policy HH.2002Δ: Sanctions
G. Title 22, California Code of Regulations (CCR), §§ 51002, 53220, 53222, and 53210(d)
H. Title 42, Code of Federal Regulation (CFR), §447.15

VI. REGULATORY AGENCY APPROVAL

Date	Regulatory Agency
07/14/2010	Department of Health Care Services (DHCS)

VII. BOARD ACTION

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	08/01/2010	AA.1220	Member Billing	Medi-Cal
Revised	09/01/2016	AA.1220	Member Billing	Medi-Cal
Revised	10/01/2017	AA.1220	Member Billing	Medi-Cal
Revised		AA.1220	Member Billing	Medi-Cal

IX. GLOSSARY

Term	Definition
Affiliate	For the purposes of this policy, means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with CalOptima and that provides service to, or receives services from, CalOptima.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Covered Services	Medical services rendered by a non-Medi-Cal Provider; or Medical services in the following categories of services for which: 1. An authorization request must be submitted and approved before CalOptima will pay; or

Term	Definition
	2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima because the service is not considered medically necessary.
Other Health Coverage (OHC)	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Provider	For the purpose of this policy, a person or institution that furnishes Covered Services to Members.
Retroactive Eligibility	Eligibility for Medi-Cal and the CalOptima program established retrospectively by the County of Orange Social Services Agency.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.

1

[TODAY'S DATE]

[BILLER NAME]
ATTN: [BILLER OFFICE STAFF NAME]

FAX: [FAX NUMBER]

RE: CalOptima Member Receiving Bill for Services

Member Name: [MEMBER'S NAME]
Member Date of Birth: [DATE]
CIN: [CIN]
Date of Service: [DATE OF SERVICE]
Account #: [ACCOUNT #]
Total Charges: [TOTAL CHARGES]

The above CalOptima member received a bill from your office or biller for services covered by Medi-Cal/Medicaid. On the date(s) of service indicated above, this member was eligible for Medi-Cal, with no share of cost through [HN NAME].

Title 22 of the California Regulatory Code, Section 53220, states that a Medi-Cal beneficiary with no share of cost is not required to pay for Medi-Cal covered services and that a Medi-Cal provider may not bill the member for such services. Therefore, your billing efforts against this member are in violation of the California Regulatory Code and must cease immediately.

As this member was enrolled in [HN NAME] on the date(s) of service, you may submit your claims to the following address for consideration:

[HN NAME]
[ADDRESS TO SUBMIT CLAIMS]

If you have any questions, please contact [HEALTH NETWORK] at [HN PHONE NUMBER].

Sincerely,

CalOptima
Customer Service Department

cc: [MEMBER NAME]
[HN NAME]

[TODAY'S DATE]

[BILLER NAME]
ATTN: [BILLER OFFICE STAFF NAME]

FAX: [FAX NUMBER]

RE: CalOptima Member Receiving Bill for Services

Member Name: [MEMBER'S NAME]
Member Date of Birth: [DATE]
CIN: [CIN]
Date of Service: [DATE OF SERVICE]
Account #: [ACCOUNT #]
Total Charges: [TOTAL CHARGES]

The above CalOptima member received a bill from your office or biller for services covered by Medi-Cal/Medicaid. On the date(s) of service indicated above, this member was eligible for Medi-Cal, with no Share of Cost, through CalOptima Direct and or CalOptima Community Network.

Title 22 of the California Regulatory Code, Section 53220, states that a Medi-Cal beneficiary with no share of cost is not required to pay for Medi-Cal covered services and that a Medi-Cal provider may not bill the member for such services. Therefore, your collection efforts against this member are in violation of the California Regulatory Code and must cease immediately.

As this member was enrolled in CalOptima Direct/CalOptima Community Network on the date(s) of service, you may submit your claims to the following address for consideration:

CalOptima Claims Department
P.O. Box 11037
Orange, CA 92856

If you have any questions, please contact CalOptima at 888-587-8088, Monday through Friday from 8 a.m. to 5:30 p.m.

Sincerely,

CalOptima
Customer Service Department

cc: [MEMBER NAME]

Policy:	DD.2006
Title:	**Enrollment In/Eligibility with CalOptima Direct**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	10/01/1995
Revision Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a Member~~*~~ in CalOptima Direct.

II. POLICY

A. CalOptima may enroll a Member in CalOptima Direct, in accordance with this Policy.

B. CalOptima shall enroll the following Members in CalOptima Direct Administrative (COD-A) subject to the provisions of this Policy:

1. A Member who has Medicare coverage and is not enrolled in OneCare or OneCare Connect.

2. A member who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and placed outside of Orange County.

3. A Member with a Share of Cost (SOC) Aid Code.

~~4. A **Member** who resides at the Fairview Developmental Center.~~

~~5.~~4. At the time of initial enrollment in CalOptima, a Member with a non-Orange County zip code, or invalid address information from the State.

a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the Member select a Health Network or CalOptima Community Network (CCN), in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. CalOptima shall enroll a Member in CCN in the following circumstances, unless eligible for enrollment in COD-A under Section II.B.:

1. A Member with Long Term Care (LTC) Aid Code;

2. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) primary Aid Code;

~~* Terms in **bold** are defined in the Glossary.~~

3. A Health Network Eligible Member~~, except as otherwise identified in this Policy,~~ who ~~is at least twenty-one (21) years old. The age provision shall no longer apply on and after the implementation date of the Department of Health Care Services (DHCS) approved Whole Child Model (WCM) program, and~~:

   a. Is diagnosed with hemophilia;

   b. Is listed for a Solid Organ Transplant or approved for a Bone Marrow Transplant (BMT).

   c. Has received a Solid Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima; or

   d. Is diagnosed with End Stage Renal Disease (ESRD).

D. If a Member is no longer required to be enrolled in COD-A or CCN as described in Sections II.B or II.C, such Member:

   1. Is a Health Network Eligible Member;

   2. May select CalOptima Community Network or any other Health Network in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a Health Network Eligible Member from the provisions of this Policy if such Member is enrolled in a Health Maintenance Organization (HMO) that, pursuant to the Health Network's Contract, is responsible for all Covered Services for the Member.

F. COD-A is responsible for a Health Network Eligible Member until such Member selects a Health Network or is assigned to a Health Network, pursuant to CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment, respectively.

G. CalOptima Direct is not responsible for Covered Services provided to a Member outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a Member with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such Member shall not be auto-assigned by CalOptima, and the Member shall remain in COD-A.

B. If a Member assigned to COD-A due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the Member select a Health Network or CCN, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto-assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. If a current Member assigned to a Health Network has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to verify a zip code within Orange County at a later date, the Member may remain with their assigned

Health Network unless Member makes a different Health Network choice or meets the criteria for COD-A or CCN enrollment as stated in Section II.B or II.C.

D. If a Health Network Eligible Member becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The Member's Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the Member in COD-A.

   a. If CalOptima receives such request to enroll the Member in COD-A by the tenth (10th) calendar day of the month, CalOptima Direct shall assume responsibility for all Covered Services for the Member effective the first (1st) calendar day of the immediately following month.

   b. If CalOptima receives such request after the tenth (10th) calendar day of the month, COD-A shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month.

2. If the Member's Public Guardian, or Orange County Children and Family Services does not submit a written request to enroll the Member in CalOptima Direct, the Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the Division of Financial Responsibility (DOFR).

3. If the Member returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the Member in a Health Network or CCN.

E. If a Health Network Eligible Member is diagnosed with Hemophilia:

1. The Member's Health Network shall notify CalOptima of the Member's diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

   a. If the Health Network notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective the first (1st) calendar day of the immediately following month.

   b. If the Health Network notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, to enroll the Member in CalOptima Direct, and CalOptima transitions such Member to CCN, as set forth in Section III.E.1 of this Policy.

F. If a Health Network Eligible Member, is listed for a Solid Organ Transplant or approved for a BMT.

1. The Member's Health Network shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

   a. Except as set forth in Section III.F.1.b of this Policy, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the Health Network.

b. If the Member receives a Solid Organ Transplant or BMT after the date the Health Network notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month of notice.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, and CalOptima transitions such Member to CalOptima Direct as set forth in Section III.F.1. of this Policy.

3. CCN shall be responsible for all Covered Services for the Member for three- hundred sixty-five (365) calendar days after the Member receives a Solid Organ Transplant or BMT. After three-hundred sixty-five (365) calendar days after the date the Member receives a Solid Organ Transplant or BMT, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the CCS-paneled Transplant Special Care Center, determines that the Member is ineligible for a Solid Organ Transplant or BMT:

a. If it has been less than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall transition the Member to the Member's previous Health Network, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the Member is ineligible for a Solid Organ Transplant or BMT; or

b. If it has been more than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a Health Network Eligible Member, except a Kaiser Member, is identified as a potential candidate for a Solid Organ Transplant or a BMT:

1. The Member's Health Network shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the Health Network, for a period of not less than three hundred sixty-five (365) calendar days after the date the Member received such Transplant.

3. CalOptima shall transition the Member to the Member's previous Health Network, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the Member received a Solid Organ Transplant or BMT.

4. The Member's Health Network shall be responsible for all Covered Services for the Member until the Health Network submits written notice and CalOptima transitions such Member to CCN, as set forth in Section III.G.1 and III.G.2 of this Policy.

H. If a Health Network Eligible Member is diagnosed with ESRD and is not already assigned to CCN:

1. The Member's Health Network shall notify CalOptima, in writing, of the Member by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

   a. If a Health Network submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month. For example, if a Health Network submits Form CMS-2728-U3 on June 15, CCN shall assume responsibility for the Member effective August 1.

   b. If a Health Network submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a Health Network submits Form CMS-2728-U3 on June 16, CCN shall assume responsibility for the Member effective September 1.

   c. CalOptima shall provide the Member with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a Member who meets the requirements specified in Sections II.B and II.C, of this Policy, CalOptima shall transition the Member to COD-A, or CCN, and notify the Member's Health Network of such transition. CalOptima shall provide the Member, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until CalOptima enrolls the Member in COD-A or CCN.

J. If CalOptima identifies a Member who meets the requirements specified in Section II.B.1. of this Policy, CalOptima shall assign the Member a PCP as follows:

1. For a member who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in CalOptima Direct pursuant to this Policy, CalOptima shall not be required to assign such members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the policy of the Department of Health Care Services (DHCS).

2. For a member who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in CalOptima Direct, pursuant to this Policy, CalOptima shall assign such member to a Medi-Cal PCP in accordance with DHCS policy(s).

3. For an existing Member assigned to a Health Network, who gains Part A-only Dual status, CalOptima shall transition the Member to COD-A in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

   a. CalOptima shall assign the Member a PCP in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

4. For a newly enrolled Member who is also Medicare Part A-only Dual eligible, CalOptima shall assign the Member to a PCP in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire
C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
~~C. CalOptima Policy AA.1000: Glossary of Terms~~
~~D.~~C. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
~~E.~~D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
~~F.~~E. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
~~G.~~F. CalOptima Policy FF.1001: Capitation Payment
~~H.~~G. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
~~I.~~H. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
~~J.~~I. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
~~K.~~J. California Health and Safety Code, §§ 104160 through 104163
~~L.~~K. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
~~M.~~L. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
~~N.~~M. Title 22, California Code of Regulations, §51006
~~O.~~N. Welfare and Institutions Code, ~~§§ 4474.6 and~~ 14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/01/2012	Department of Health Care Services (DHCS)
04/01/2015	Department of Health Care Services (DHCS)
08/18/2015	Department of Health Care Services (DHCS)
10/07/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
10/09/2006	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
03/04/2010	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
04/04/2019	Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised		DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal covered services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A member who receives all covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as ~~covered services~~Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for ~~members~~Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to members assigned to that health network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima health network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Care Provider (PCP)	~~A Primary Care Provider may be a Primary Care Practitioner, or other institution or facility~~A person responsible for supervising, coordinating, and providing initial and ~~primary care~~Primary Care to ~~members and serves as~~patients; for initiating referrals; and, for maintaining the ~~medical home for members.~~continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combined liver and small bowel; ~~and~~or 9. Combined kidney and pancreas.
Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

Policy:	DD.2006
Title:	**Enrollment In/Eligibility with CalOptima Direct**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	10/01/1995
Revision Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the criteria by which CalOptima enrolls a Member in CalOptima Direct.

II. POLICY

A. CalOptima may enroll a Member in CalOptima Direct, in accordance with this Policy.

B. CalOptima shall enroll the following Members in CalOptima Direct Administrative (COD-A) subject to the provisions of this Policy:

1. A Member who has Medicare coverage and is not enrolled in OneCare or OneCare Connect.

2. A member who becomes the responsibility of the Public Guardian or is in an Institute for Mental Disease (IMD), or with Orange County Children and Family Services and placed outside of Orange County.

3. A Member with a Share of Cost (SOC) Aid Code.

4. At the time of initial enrollment in CalOptima, a Member with a non-Orange County zip code, or invalid address information from the State.

   a. If the address and/or zip code changes to an Orange County address at a later date, CalOptima shall request that the Member select a Health Network or CalOptima Community Network (CCN), in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. CalOptima shall enroll a Member in CCN in the following circumstances, unless eligible for enrollment in COD-A under Section II.B.:

1. A Member with Long Term Care (LTC) Aid Code;

2. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) primary Aid Code;

3. A Health Network Eligible Member who:

   a. Is diagnosed with hemophilia;

Back to Agenda Back to Item

b. Is listed for a Solid Organ Transplant or approved for a Bone Marrow Transplant (BMT).

c. Has received a Solid Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima; or

d. Is diagnosed with End Stage Renal Disease (ESRD).

D. If a Member is no longer required to be enrolled in COD-A or CCN as described in Sections II.B or II.C, such Member:

1. Is a Health Network Eligible Member;

2. May select CalOptima Community Network or any other Health Network in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

E. CalOptima shall exclude a Health Network Eligible Member from the provisions of this Policy if such Member is enrolled in a Health Maintenance Organization (HMO) that, pursuant to the Health Network's Contract, is responsible for all Covered Services for the Member.

F. COD-A is responsible for a Health Network Eligible Member until such Member selects a Health Network or is assigned to a Health Network, pursuant to CalOptima Policies DD.2008: Health Network and CalOptima Community Network Selection Process or AA.1207a: CalOptima Auto-Assignment, respectively.

G. CalOptima Direct is not responsible for Covered Services provided to a Member outside the United States, with the exception of Emergency Services requiring hospitalization in Canada or Mexico, in accordance with Title 22, California Code of Regulations, Section 51006.

III. PROCEDURE

A. At the time of initial enrollment in CalOptima, a Member with a zip code outside of Orange County, as indicated by the eligibility file sent to CalOptima by the State, or, if CalOptima is unable to verify a zip code within Orange County due to no address information provided by the State, such Member shall not be auto-assigned by CalOptima, and the Member shall remain in COD-A.

B. If a Member assigned to COD-A due to having a zip code outside Orange County changes his or her zip code to an Orange County zip code, CalOptima shall request that the Member select a Health Network or CCN, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If the Member fails to choose a Health Network or CCN, then CalOptima shall auto-assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

C. If a current Member assigned to a Health Network has or receives a zip code outside of Orange County as indicated by the eligibility file sent to CalOptima by the State, or CalOptima is unable to verify a zip code within Orange County at a later date, the Member may remain with their assigned Health Network unless Member makes a different Health Network choice or meets the criteria for COD-A or CCN enrollment as stated in Section II.B or II.C.

D. If a Health Network Eligible Member becomes the responsibility of the Public Guardian, or is in an Institute for Mental Disease, or is with Orange County Children and Family Services and resides outside Orange County:

1. The Member's Public Guardian, or the Orange County Children and Family Services may submit a written request to enroll the Member in COD-A.

    a. If CalOptima receives such request to enroll the Member in COD-A by the tenth (10th) calendar day of the month, CalOptima Direct shall assume responsibility for all Covered Services for the Member effective the first (1st) calendar day of the immediately following month.

    b. If CalOptima receives such request after the tenth (10th) calendar day of the month, COD-A shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month.

2. If the Member's Public Guardian, or Orange County Children and Family Services does not submit a written request to enroll the Member in CalOptima Direct, the Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the Division of Financial Responsibility (DOFR).

3. If the Member returns to Orange County, the Public Guardian or Orange County Children and Family Services may submit a written request to enroll the Member in a Health Network or CCN.

E. If a Health Network Eligible Member is diagnosed with Hemophilia:

1. The Member's Health Network shall notify CalOptima of the Member's diagnosis, in writing, using the Hemophilia Special Needs Screen Questionnaire, in accordance with CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members.

    a. If the Health Network notifies CalOptima, in writing, by the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective the first (1st) calendar day of the immediately following month.

    b. If the Health Network notifies CalOptima, in writing, after the tenth (10th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, to enroll the Member in CalOptima Direct, and CalOptima transitions such Member to CCN, as set forth in Section III.E.1 of this Policy.

F. If a Health Network Eligible Member, is listed for a Solid Organ Transplant or approved for a BMT.

1. The Member's Health Network shall notify CalOptima, in writing, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

    a. Except as set forth in Section III.F.1.b of this Policy, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the Health Network.

    b. If the Member receives a Solid Organ Transplant or BMT after the date the Health Network notifies CalOptima and before the first (1st) calendar day of the month immediately following the date CalOptima receives notice, CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month of notice.

2. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until the Health Network notifies CalOptima, in writing, and CalOptima transitions such Member to CalOptima Direct as set forth in Section III.F.1. of this Policy.

3. CCN shall be responsible for all Covered Services for the Member for three- hundred sixty-five (365) calendar days after the Member receives a Solid Organ Transplant or BMT. After three-hundred sixty-five (365) calendar days after the date the Member receives a Solid Organ Transplant or BMT, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

4. If CalOptima, the DHCS-approved Transplant Center, or the CCS-paneled Transplant Special Care Center, determines that the Member is ineligible for a Solid Organ Transplant or BMT:

   a. If it has been less than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall transition the Member to the Member's previous Health Network, effective the first (1st) calendar day of the month immediately following the date CalOptima or the DHCS-approved Transplant Center determines that the Member is ineligible for a Solid Organ Transplant or BMT; or

   b. If it has been more than three hundred sixty-five (365) calendar days after the Member transitioned to CCN, CalOptima shall request the Member select a Health Network, in accordance with CalOptima Policy DD.2008: Health Network Selection Process, or CalOptima shall auto assign the Member, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

G. If a Health Network Eligible Member, except a Kaiser Member, is identified as a potential candidate for a Solid Organ Transplant or a BMT:

1. The Member's Health Network shall notify CalOptima by sending a Notification of Transplant Member, in accordance with CalOptima Policy GG.1313: Coordination of Care for Transplant Members.

2. CCN shall assume responsibility for all Covered Services for the Member on the first (1st) calendar day of the month immediately following the date CalOptima receives written notice from the Health Network, for a period of not less than three hundred sixty-five (365) calendar days after the date the Member received such Transplant.

3. CalOptima shall transition the Member to the Member's previous Health Network, effective no later than the first (1st) calendar day of the month immediately following the three hundred sixty fifth (365th) calendar day after the date the Member received a Solid Organ Transplant or BMT.

4. The Member's Health Network shall be responsible for all Covered Services for the Member until the Health Network submits written notice and CalOptima transitions such Member to CCN, as set forth in Section III.G.1 and III.G.2 of this Policy.

H. If a Health Network Eligible Member is diagnosed with ESRD and is not already assigned to CCN:

1. The Member's Health Network shall notify CalOptima, in writing, of the Member by submitting a copy of Form CMS-2728-U3 to CalOptima's Health Network Relations Department.

a. If a Health Network submits a Form CMS-2728-U3 on or before the fifteenth (15th) calendar day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the month after the immediately following month. For example, if a Health Network submits Form CMS-2728-U3 on June 15, CCN shall assume responsibility for the Member effective August 1.

b. If a Health Network submits a Form CMS-2728-U3 after the fifteenth (15th) day of a month, CCN shall assume responsibility for all Covered Services for the Member effective no later than the first (1st) calendar day of the second (2nd) month after the immediately following month. For example, if a Health Network submits Form CMS-2728-U3 on June 16, CCN shall assume responsibility for the Member effective September 1.

c. CalOptima shall provide the Member with a thirty (30) calendar day notice of the transition, pursuant to the CalOptima Contract with DHCS.

I. If CalOptima identifies a Member who meets the requirements specified in Sections II.B and II.C, of this Policy, CalOptima shall transition the Member to COD-A, or CCN, and notify the Member's Health Network of such transition. CalOptima shall provide the Member, with a thirty (30) calendar day notice of the transition pursuant to CalOptima's contract with DHCS.

1. The Member's Health Network shall be responsible for all Covered Services for the Member, in accordance with the DOFR, until CalOptima enrolls the Member in COD-A or CCN.

J. If CalOptima identifies a Member who meets the requirements specified in Section II.B.1. of this Policy, CalOptima shall assign the Member a PCP as follows:

1. For a member who has both Medicare Parts A and B or Medicare Part B coverage and is enrolled in CalOptima Direct pursuant to this Policy, CalOptima shall not be required to assign such members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider (PCP) or require them to select a Medi-Cal PCP in accordance with the policy of the Department of Health Care Services (DHCS).

2. For a member who has Medicare Part A coverage, but does not have Medicare Part B coverage, and is enrolled in CalOptima Direct, pursuant to this Policy, CalOptima shall assign such member to a Medi-Cal PCP in accordance with DHCS policy(s).

3. For an existing Member assigned to a Health Network, who gains Part A-only Dual status, CalOptima shall transition the Member to COD-A in the month CalOptima is notified by the State of the change to Medicare Part A eligibility.

a. CalOptima shall assign the Member a PCP in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

4. For a newly enrolled Member who is also Medicare Part A-only Dual eligible, CalOptima shall assign the Member to a PCP in accordance with the methodology described in CalOptima Policy DD.2006b: CalOptima Community Network Primary Care Provider Selection/Assignment.

5. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima's Customer Service Department.

IV. ATTACHMENT(S)

A. Notification of Transplant Member
B. Hemophilia Special Needs Screen Questionnaire

C. End Stage Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3)

V. REFERENCE(S)

A. CalOptima Contract with Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Services
C. CalOptima Policy AA.1207a: CalOptima Auto-Assignment
D. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
E. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
F. CalOptima Policy FF.1001: Capitation Payment
G. CalOptima Policy GG.1304: Continuity of Care During Health Network or Provider Termination
H. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
I. CalOptima Policy GG.1318: Coordination of Care for Hemophilia Members
J. California Health and Safety Code, §§ 104160 through 104163
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-015: PCP Assignment in Medi-Cal Managed Care for Dual-Eligible Beneficiaries
L. Department of Health Care Services All Plan Letter (APL) 18-023: California Children's Services Whole Child Model Program
M. Title 22, California Code of Regulations, §51006
N. Welfare and Institutions Code, §§ 4474.6 and 14182.17(d)(3)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
10/01/2012	Department of Health Care Services (DHCS)
04/01/2015	Department of Health Care Services (DHCS)
08/18/2015	Department of Health Care Services (DHCS)
10/07/2015	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
10/09/2006	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
03/04/2010	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
04/04/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	02/01/1996	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	03/01/1997	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	09/01/2004	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	01/01/2006	DD.2006	CalOptima Direct Responsibilities	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2007	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2008	DD.2006	CalOptima Direct Responsibilities	Medi-Cal
Revised	07/01/2010	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	01/01/2011	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	10/01/2012	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	03/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	05/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/01/2015	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Reviewed	02/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	07/01/2016	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	09/06/2018	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised	04/04/2019	DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal
Revised		DD.2006	Enrollment In/Eligibility with CalOptima Direct	Medi-Cal

1

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a member is eligible to receive Medi-Cal covered services.
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
California Children's Services (CCS) Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the member.
CalOptima Direct (COD)	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct (COD) Member	A member who receives all covered services through CalOptima Direct.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division Of Financial Responsibility (DOFR)	A matrix that defines how CalOptima identifies the responsible parties for components of medical associated with the provision of covered services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.

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Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
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Status 7	Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

1

CalOptima
A Public Agency
Better. Together.

P.O. BOX 11033, ORANGE, CA 92856 Phone: 714-246-8686

ADULT TRANSPLANT NOTIFICATION AND REQUEST FORM

Fax Submissions: Urgent: 714-796-6616 Routine: 714-796-6607

PHASE: ☐ New Referral ☐ Evaluation ☐ Listed ☐ Transplant ☐ Post-Transplant

***** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last / First) ☐ M ☐ F D.O.B. _____ Age: _____

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____

Referring Provider:

Provider NPI#: _____ TIN#: _____

Medi-Cal ID#: _____

Address: Phone: _____

Fax: _____

Office Contact: _____

Physician's Signature: _____

Diagnosis: _____ ICD-9: _____

TRANSPLANT TYPE
(CalOptima may redirect based on contract status or center availability)

BMT:	☐ Cedars	
DLI:	☐ Cedars	
Kidney:	☐ UCI	
Kidney Pancreas:	☐ California Pacific	☐ UCSF
Liver:	☐ Cedars	☐ USC
Liver and Kidney:	☐ Cedars	☐ USC
Lung:	☐ USC	
Heart:	☐ Cedars	☐ USC
Heart and Lung:	☐ Stanford	
Small Bowel:	☐ Cedars	☐ USC

☐ Inpatient ☐ Outpatient

Estimated Length of Stay: _____

Letter of Agreement (LOA) Requested

Date(s) of Service: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting medical records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

STATUS	Authorization Number #
☐ Approved ☐ Modified ☐ Denied	Signature: Date:
☐ Not Medically Indicated ☐ Not a Covered Benefit	Comments:
☐ Services Available In Network	

Back to Agenda Back to Item

CalOptima
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Special Needs Screen Questionnaire for Member with Hemophilia Transitioning from Health Networks to CalOptima Direct

☐ Hemophilia A ☐ Hemophilia B ☐ Hemophilia C ☐ von Willebrands Disease

Name: CIN #: Phone No: ( ) -

Health Network: HN Contact: Phone No: ( ) -

Primary Care Physician: Phone No: ( ) -

Treating Specialists: Phone No: ( ) -

Is Member currently in Case Management?

*If member is in case management, submit a case summary.

Planned Admissions or scheduled surgeries:

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Date of Procedure: - - Type of Procedure:

Comments (include CPT and ICD-9 codes requested/authorized):

What factor is utilized?

Name of Provider/Vendor: Phone No: ( ) -

Ordering Physician: Phone No: ( ) -

Comments (include CPT and ICD-9 codes requested/authorized):

Has the member been hospitalized in the past six months? ☐ Yes ☐ No

If yes:

Hospital:

Diagnosis:

RX

(Please make copies of this page if additional space needed for medications)

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of medication:

Strength:

Route:

Frequency:

Name of person completing this form: Date: - -

PLEASE SEND A COPY OF ALL OPEN AUTHORIZATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS *Check one:* ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Beneficiary Identifier or Social Security Number

3. Date of Birth *(mm/dd/yyyy)*

4. Patient Mailing Address *(Include City, State and Zip)*

5. Phone Number *(including area code)*

6. Sex
☐ Male ☐ Female

7. Ethnicity
☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

8. Country/Area of Origin or Ancestry

9. Race *(Check all that apply)*
☐ White
☐ Black or African American
☐ American Indian/Alaska Native
Print Name of Enrolled/Principal Tribe _____
☐ Asian
☐ Native Hawaiian or Other Pacific Islander*
☐ Other

10. Is patient applying for ESRD Medicare coverage?
☐ Yes ☐ No

11. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ VA ☐ Medicare Advantage ☐ Other ☐ None

12. Height
INCHES _____ OR
CENTIMETERS _____

13. Dry Weight
POUNDS _____ OR
KILOGRAMS _____

14. Primary Cause of Renal Failure *(Use code from back of form)*

15. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

16. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions
a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*
f. ☐ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. ☐ Institutionalized
☐ 1. Assisted Living
☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

17. Prior to ESRD therapy:
a. Did patient receive exogenous erythropoetin or equivalent? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
b. Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
c. Was patient under care of kidney dietitian? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months
d. What access was used on first outpatient dialysis: ☐ AVF ☐ Graft ☐ Catheter ☐ Other
If not AVF, then: Is maturing AVF present? ☐ Yes ☐ No
Is maturing graft present? ☐ Yes ☐ No

18. Laboratory Values Within **45** Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)	___.___		d. HbA1c	___ ___.___%	
a.2. Serum Albumin Lower Limit	___.___		e. Lipid Profile TC	___ ___ ___	
a.3. Lab Method Used (BCG or BCP)			LDL	___ ___ ___	
b. Serum Creatinine (mg/dl)	___ ___.___		HDL	___ ___	
c. Hemoglobin (g/dl)	___ ___.___		TG	___ ___ ___ ___	

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

19. Name of Dialysis Facility

20. Medicare Provider Number *(for item 19)*

21. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility ☐ SNF/Long Term Care Facility

22. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ CAPD ☐ CCPD ☐ Other

23. Date Regular Chronic Dialysis Began *(mm/dd/yyyy)*

24. Date Patient Started Chronic Dialysis at Current Facility *(mm/dd/yyyy)*

25. Has patient been informed of kidney transplant options?
☐ Yes ☐ No

26. If patient NOT informed of transplant options, please check all that apply:
☐ Patient declined information
☐ Patient has not been assessed
☐ Patient is not eligible medically
☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

27. Date of Transplant *(mm/dd/yyyy)*	28. Name of Transplant Hospital	29. Medicare Provider Number for Item 28

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

30. Enter Date *(mm/dd/yyyy)*	31. Name of Preparation Hospital	32. Medicare Provider number for Item 31

33. Current Status of Transplant *(if functioning, skip items 36 and 37)*	34. Type of Donor:
☐ Functioning ☐ Non-Functioning	☐ Deceased ☐ Living Related ☐ Living Unrelated
35. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*	36. Current Dialysis Treatment Site
	☐ Home ☐ Dialysis Facility ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

37. Name of Training Provider	38. Medicare Provider Number of Training Provider (for Item 37)
39. Date Training Began *(mm/dd/yyyy)*	40. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other
41. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	42. Date When Patient Completed, or is Expected to Complete, Training *(mm/dd/yyyy)*

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

43. Printed Name and Signature of Physician personally familiar with the patient's training			44. UPIN or NPI of Physician in Item 43
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

E. PHYSICIAN IDENTIFICATION

45. Attending Physician *(Print)*	46. Physician's Phone No. *(include Area Code)*	47. UPIN or NPI of Physician in Item 45

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

48. Attending Physician's Signature of Attestation *(Same as Item 45)*	49. Date *(mm/dd/yyyy)*
50. Physician Recertification Signature	51. Date *(mm/dd/yyyy)*

52. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

53. Signature of Patient *(Signature by mark must be witnessed.)*	54. Date *(mm/dd/yyyy)*

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-700520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the Federal Register notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

LIST OF PRIMARY CAUSES OF RENAL DISEASE

Item 14. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-10-CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. **An ICD-10-CM code is effective as of October 1, 2015.**

ICD-10	DESCRIPTION
DIABETES	
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
GLOMERULONEPHRITIS	
N00.8	Acute nephritic syndrome with other morphologic changes
N01.9	Rapidly progressive nephritic syndrome with unspecified morphologic changes
N02.8	Recurrent and persistent hematuria with other morphologic changes
N03.0	Chronic nephritic syndrome with minor glomerular abnormality
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions
N03.2	Chronic nephritic syndrome with diffuse membranous glomerulonephritis
N03.3	Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis
N03.4	Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis
N03.5	Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis
N03.6	Chronic nephritic syndrome with dense deposit disease
N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis
N03.8	Chronic nephritic syndrome with other morphologic changes
N03.9	Chronic nephritic syndrome with unspecified morphologic changes
N04.0	Nephrotic syndrome with minor glomerular abnormality
N04.1	Nephrotic syndrome with focal and segmental glomerular lesions
N04.2	Nephrotic syndrome with diffuse membranous glomerulonephritis
N04.3	Nephrotic syndrome with diffuse mesangial proliferative glomerulonephritis
N04.4	Nephrotic syndrome with diffuse endocapillary proliferative glomerulonephritis
N04.5	Nephrotic syndrome with diffuse mesangiocapillary glomerulonephritis
N04.6	Nephrotic syndrome with dense deposit disease
N04.7	Nephrotic syndrome with diffuse crescentic glomerulonephritis
N04.8	Nephrotic syndrome with other morphologic changes
N04.9	Nephrotic syndrome with unspecified morphologic changes
N05.9	Unspecified nephritic syndrome with unspecified morphologic changes
N07.0	Hereditary nephropathy, not elsewhere classified with minor glomerular abnormality
SECONDARY GLOMERULONEPHRITIS/VASCULITIS	
D59.3	Hemolytic-uremic syndrome
D69.0	Allergic purpura
I77.89	Other specified disorders of arteries and arterioles
M31.0	Hypersensitivity angiitis
M31.1	Thrombotic microangiopathy
M31.31	Wegener's granulomatosis with renal involvement
M31.7	Microscopic polyangiitis
M32.0	Drug-induced systemic lupus erythematosus
M32.10	Systemic lupus erythematosus, organ or system involvement unspecified
M32.14	Glomerular disease in systemic lupus erythematosus
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus
M34.89	Other systemic sclerosis
INTERSTITIAL NEPHRITIS/PYELONEPHRITIS	
N10	Acute tubulo-interstitial nephritis
N11.9	Chronic tubulo-interstitial nephritis, unspecified
N13.70	Vesicoureteral-reflux, unspecified
N13.8	Other obstructive and reflux uropathy 2
TRANSPLANT COMPLICATIONS	
T86.00	Unspecified complication of bone marrow transplant
T86.10	Unspecified complication of kidney transplant
T86.20	Unspecified complication of heart transplant
T86.40	Unspecified complication of liver transplant
T86.819	Unspecified complication of lung transplant
T86.859	Unspecified complication of intestine transplant
T86.899	Unspecified complication of other transplanted tissue

LIST OF PRIMARY CAUSES OF RENAL DISEASE

Item 14. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-10-CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. **An ICD-10-CM code is effective as of October 1, 2015.**

ICD-10	DESCRIPTION
HYPERTENSION/LARGE VESSEL DISEASE	
I12.9	Hypertensive chronic kidney disease with stage 1through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I15.0	Renovascular hypertension
I15.8	Other secondary hypertension
I75.81	Atheroembolism of kidney
CYSTIC/HEREDITARY/CONGENITAL/OTHER DISEASES	
E72.04	Cystinosis
E72.53	Hyperoxaluria
E75.21	Fabry (-Anderson) disease
N07.8	Hereditary nephropathy, not elsewhere classified with other morphologic lesions
N31.9	Neuromuscular dysfunction of bladder, unspecified
Q56.0	Hermaphroditism, not elsewhere classified
Q60.2	Renal agenesis, unspecified
Q61.19	Other polycystic kidney, infantile type
Q61.2	Polycystic kidney, adult type
Q61.4	Renal dysplasia
Q61.5	Medullary cystic kidney
Q61.8	Other cystic kidney diseases
Q62.11	Congenital occlusion of ureteropelvic junction
Q62.12	Congenital occlusion of ureterovesical orifice
Q63.8	Other specified congenital malformations of kidney
Q64.2	Congenital posterior urethral valves
Q79.4	Prune belly syndrome
Q85.1	Tuberous sclerosis
Q86.8	Other congenital malformation syndromes due to known exogenous causes
Q87.1	Congenital malformation syndromes predominantly associated with short stature
Q87.81	Alport syndrome
NEOPLASMS/TUMORS	
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C80.1	Malignant (primary) neoplasm, unspecified
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C88.2	Heavy chain disease
C90.00	Multiple myeloma not having achieved remission
D30.9	Benign neoplasm of urinary organ, unspecified
D41.00	Neoplasm of uncertain behavior of unspecified kidney
D41.9	Neoplasm of uncertain behavior of unspecified urinary organ
E85.9	Amyloidosis, unspecified
N05.8	Unspecified nephritic syndrome with other morphologic changes
DISORDERS OF MINERAL METABOLISM	
E83.52	Hypercalcemia
GENITOURINARY SYSTEM	
A18.10	Tuberculosis of genitourinary system, unspecified
N28.9	Disorder of kidney and ureter, unspecified
ACUTE KIDNEY FAILURE	
N17.0	Acute kidney failure with tubular necrosis
N17.1	Acute kidney failure with acute cortical necrosis
N17.9	Acute kidney failure, unspecified
MISCELLANEOUS CONDITIONS	
B20	Human immunodeficiency virus [HIV] disease
D57.1	Sickle-cell disease without crisis
D57.3	Sickle cell trait
I50.9	Heart failure, unspecified
K76.7	Hepatorenal syndrome
M10.30	Gout due to renal impairment, unspecified site
N14.0	Analgesic nephropathy
N14.1	Nephropathy induced by other drugs, medicaments and biological substances
N14.3	Nephropathy induced by heavy metals
N20.0	Calculus of kidney
N25.89	Other disorders resulting from impaired renal tubular function
N26.9	Renal sclerosis, unspecified
N28.0	Ischemia and infarction of kidney
N28.89	Other specified disorders of kidney and ureter
O90.4	Postpartum acute kidney failure
S37.009A	Unspecified injury of unspecified kidney, initial encounter
Z90.5	Acquired Absence of Kidney

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form **SHOULD NOT** be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form **MUST BE** completed within 45 days for **ALL** patients beginning any of the following:

Check the appropriate block that identifies the reason for submission of this form.

Initial

For all patients who initially receive a kidney transplant instead of a course of dialysis.

For patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient. The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

All items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease.

Items 14, 16-17, 25-26, 48-49: To be completed by the attending physician.
Item 43: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
Items 53 and 54: To be signed and dated by the patient.

1. Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.
2. If the patient is covered by Medicare, enter his/her Medicare Beneficiary Identifier as it appears on his/her Medicare card. If the patient has not yet been assigned a Medicare Beneficiary Identifier, enter the Social Security Number as it appears on his/her Social Security Card. **Only enter the Social Security Number if the patient does not have a Medicare Beneficiary Identifier**.
3. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
4. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
5. Enter the patient's home area code and telephone number.
6. Check the appropriate block to identify sex.
7. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Please complete Item 9 and provide the country, area of origin, or ancestry to which the patient claims to belong.
8. Country/Area of origin or ancestry—Complete if information is available or if directed to do so in question 9.
9. Check the appropriate block(s) to identify race. The 1997 OMB standards permit the reporting of more than one race. An individual's response to the race question is based upon self-identification.

   Definitions of the racial categories for Federal statistics are as follows:

   White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

   Black or African American—A person having origins in any of the Black racial groups of Africa.

   American Indian/Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

   Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   Native Hawaiian or Other Pacific Islander—AA person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   Other Race—For respondents unable to identify with any of these five race categories
10. Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. **Note: Even though a person may already be entitled to general Medicare coverage, he/she should reapply for ESRD Medicare coverage.**

DISTRIBUTION OF COPIES:

- **To the Applicant:** Forward the hard copy of this form with original signatures to the Social Security office servicing the claim.
- **To the Dialysis Facility:** Complete the form in Crown Web or maintain a copy with signature's in the patient file.

11. Check **all** the blocks that apply to this patient's current medical insurance status.

    Medicaid—Patient is currently receiving State Medicaid benefits.

    Medicare—Patient is currently entitled to Federal Medicare benefits.

    Employer Group Health Insurance—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees or former employees.

    VA—Patient is receiving medical care from a Department of Veterans Affairs facility.

    Medicare Advantage—Patient is receiving medical benefits under a Medicare Advantage organization.

    Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, HMO/M+C organization, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

    None—Patient has no medical insurance plan.

12. Enter the patient's most recent recorded height in inches **OR** centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

13. Enter the patient's most recent recorded dry weight in pounds **OR** kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

14. Primary Cause of Renal Failure should be determined by the attending physician using the appropriate ICD-10-CM code. Enter the ICD-10-CM code from page 3 or 4 of form to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary. An ICD-10-CM code is effective as of October 1, 2015. These are the only acceptable causes of end stage renal disease.

15. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. **Check only one box for each time period**. If patient is under 6 years of age, leave blank.

16. **To be completed by the attending physician**. Check all co-morbid conditions that apply.

    ***Cerebrovascular Disease** includes history of stroke/ cerebrovascular accident (CVA) and transient ischemic attack (TIA).

    ***Peripheral Vascular Disease** includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

    ***Drug dependence** means dependent on illicit drugs.

17. Prior to ESRD therapy, check the appropriate box to indicate whether the patient received Exogenous erythropoetin (EPO) or equivalent, was under the care of a nephrologist and/or was under the care of a kidney dietitian. Provide vascular access information as to the type of access used (Arterio-Venous Fistula (AVF), graft, catheter (including port device) or other type of access) when the patient first received outpatient dialysis. If an AVF access was not used, was a maturing AVF or graft present?

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 18a thru 18c should contain initial laboratory values within 45 days prior to the most recent ESRD episode. Lipid profiles and HbA1c should be within 1 year of the most recent ESRD episode. Some tests may not be required for patients under 21 years of age.

18a1. Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or kidney transplant.

18a2. Enter the lower limit of the normal range for serum albumin from the laboratory which performed the serum albumin test entered in 19a1.

18a3. Enter the serum albumin lab method used (BCG or BCP).

18b. Enter the serum creatinine value (mg/dl) and date test was taken. **THIS FIELD MUST BE COMPLETED.** Value must be within 45 days prior to first dialysis treatment or kidney transplant.

18c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

18d. Enter the HbA1c value and the date the test was taken. The date must be within 1 year prior to the first dialysis treatment or kidney transplant.

18e. Enter the Lipid Profile values and date test was taken. These values: TC–Total Cholesterol; LDL–LDL Cholesterol; HDL–HDL Cholesterol; TG–Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19. Enter the name of the dialysis facility where patient is currently receiving care and who is completing this form for patient.

20. Enter the 6-digit Medicare identification code of the dialysis facility in item 19.

21. If the person is receiving a regular course of dialysis treatment, check the appropriate **anticipated long-term treatment setting** at the time this form is being completed.

22. If the patient is, or was, on regular dialysis, **check the anticipated long-term primary type of dialysis**: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), CAPD (Continuous Ambulatory Peritoneal Dialysis) and CCPD (Continuous Cycling Peritoneal Dialysis), or Other. **Check only one block**. NOTE: Other has been placed on this form to be used only to report IPD (Intermittent Peritoneal Dialysis) and any new method of dialysis that may be developed prior to the renewal of this form by Office of Management and Budget.

23. Enter the date (month, day, year) that a "regular course of chronic dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD) regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Chronic Dialysis Began" regardless of whether this prescription was implemented in a hospital/ inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis or a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 52, that patient is restarting dialysis.

24. Enter date patient started chronic dialysis at current facility of dialysis services. In cases where patient transferred to current dialysis facility, this date will be after the date in Item 24.

25. Enter whether the patient has been informed of their options for receiving a kidney transplant.

26. If the patient has not been informed of their options (answered "no" to Item 25), then enter all reasons why a kidney transplant was not an option for this patient at this time.

27. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.

28. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 27.

29. Enter the 6-digit Medicare identification code of the hospital in Item 28 where the patient received a kidney transplant on the date entered in Item 27.

30. Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.

31. Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.

32. Enter the 6-digit Medicare identification number for hospital in Item 31.

33. Check the appropriate functioning or non-functioning block.

34. Enter the type of kidney transplant organ donor, Deceased, Living Related or Living Unrelated, that was provided to the patient.

35. If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post transplant, enter transplant date.

36. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting.

Self-dialysis Training Patients (Medicare Applicants Only)
Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a **Medicare approved training facility** and is expected to self-dialyze after the completion of the training program. Please complete items 37-42 if the patient has entered into a self-dialysis training program. Items 37-42 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

37. Enter the name of the provider furnishing self-care dialysis training.

38. Enter the 6-digit Medicare identification number for the training provider in Item 32.

39. Enter the date self-dialysis training began.

40. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center). If the patient trained for IPD (Intermittent Peritoneal Dialysis), report as Other.

41. Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.

42. Enter date patient completed or is expected to complete self-dialysis training.

43. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.

44. Enter the National Provider Identifier (NPI) or the Unique Physician Identification Number (UPIN) of physician in Item 43. (See Item 47 for explanation of UPIN.)

45. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.

46. Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.

47. Enter the National Provider Identifier (NPI) or the Unique Physician Identification Number (UPIN) of physician in Item 45

A system of physician identifiers is mandated by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part B Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.

The NPI is established by the NPI Enumerator located in Fargo, North Dakota. The NPI Enumerator may be contacted by:

Phone: (800)465-3203 or TTY (800)692-2326.
Email: customerservice@npienumerator.com.
Mail: NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

48. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 45. A stamped signature is unacceptable.

49. Enter date physician signed this form.

50. To be signed by the physician who is currently following the patient. If the patient had decided initially not to file an application for Medicare, the physician will be re-certifying that the patient is end stage renal, based on the same medical evidence, by signing the copy of the CMS-2728 that was originally submitted and returned to the provider. If you do not have a copy of the original CMS-2728 on file, complete a new form.

51. The date physician re-certified and signed the form.

52. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.

53. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. **If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor**.

54. The date patient signed form.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Approving Modifications to CalOptima's Medi-Cal and OneCare Connect Policy GG.1822: Process for Transitioning CalOptima Members Between Levels of Care

Contacts
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400

Recommended Action
Approve modifications to CalOptima's Medi-Cal and OneCare Connect Policy GG.1822: Process for Transitioning CalOptima Members Between Levels of Care pursuant to CalOptima's regular review process and consistent with regulatory requirements.

Background/Discussion
CalOptima regularly reviews its Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations and laws as well as CalOptima operations. Following is information regarding the policy that requires modification:

- **CalOptima Policy GG.1822: *Process for Transitioning CalOptima Members Between Levels of Care*** outlines the process for transitioning CalOptima Members Between Levels of Care (LOC), as well as into and out of a Long-Term Care Facility (LTC). LOC refers to the transfer of a CalOptima Member from a skilled short stay to LTC custodial care, which may occur within the nursing facility. Proposed updates to this policy include clarification of the responsibility for transportation between an acute care facility and an LTC facility by CalOptima or the Member's Health Network. The policy was also modified to more clearly define the transition of the authorization and payment responsibilities to CalOptima when a Member transitions into custodial care. Additional updates include the inclusion of a Member and Member's family in discharge planning and care coordination activities, and updating definitions where appropriate.

Fiscal Impact
The recommended action to revise CalOptima Policy GG.1822 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

Rationale for Recommendation
To ensure CalOptima's policies reflect applicable laws, regulations, and rules, staff recommends that the Board approve the proposed updates to CalOptima Policy GG.1822: Process for Transitioning CalOptima Members Between Levels of Care. The updated policy and procedure will supersede the prior version.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. CalOptima Policy GG.1822: Process for Transitioning CalOptima Members between Levels of Care (redline and clean)

/s/ Richard Sanchez *08/26/2020*
Authorized Signature **Date**

Back to Agenda

Policy:	GG.1822
Title:	**Process for Transitioning CalOptima Members between Levels of Care**
Department:	Medical Management
Section:	Long-Term Services and Supports
CEO Approval:	
Effective Date:	03/01/1999
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for transitioning CalOptima Members between Levels of Care (LOC), as well as into and out of Long-Term Care (LTC).

II. POLICY

A. Transfer from an acute care facility to a Long-Term Care (LTC) Facility

1. The discharge planning process from the acute setting shall include a review of the Member's ability to be discharged to a community setting with referrals to Home and Community-Based Services (HCBS) and other waiver programs prior to transferring to an LTC Facility.

2. The acute care facility shall be responsible for all discharge planning aspects of a Member's transfer to an LTC Facility.

3. CalOptima, or a Health Network, may assist in coordinating the discharge planning of a Member from an acute care fFacility to an LTC Facility.

4. The acute care fFacility shall collaborate with all appropriate Interdisciplinary Care Team (ICT) staff to facilitate the transfer of the Member.

5. The admitting LTC Facility shall coordinate the medical and ancillary services with CalOptima, the Member's Health Network, and other appropriate agencies such as the Regional Center of Orange County (RCOC), as appropriate.

~~5.~~6. CalOptima~~,~~ or the Member's Health Network~~,~~ shall be responsible for a Member's transportation from an acute care facility to an LTC Facility, in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

B. Transfer from an LTC Facility to an acute care facility

1. An LTC Facility shall be responsible for coordinating a planned, emergent, or urgent transfer of a Member to an acute care fFacility.

~~* Terms in **bold** are defined in the Glossary.~~

2. An LTC Facility shall collaborate with all appropriate ICT staff to facilitate either a planned, emergent, or urgent transfer of a Member from an LTC Facility to an acute care facility.

3. The LTC Facility shall ~~-~~submit a ~~b~~Bed ~~h~~Hold payment request to the CalOptima C~~c~~laims ~~d~~Department with appropriate ~~b~~Bed ~~h~~Hold accommodation codes for LTC level of care and ~~;~~ ~~must also include b~~Bed ~~h~~Hold dates of service. ~~notify the CalOptima Long-Term Services and Supports (LTSS) Department, or the Member's Health Network, of a Member's admission to an acute care facility through the twenty-one (21) day list processes requesting a bed hold.~~

4. CalOptima~~,~~ or the Member's Health Network~~,~~ shall be responsible for a Member's transportation from an LTC~~acute care~~ ~~F~~facility to an acute care ~~LTC~~ Facility, in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

5. Nursing facility may request a bed hold while a Member is in the acute setting. If a Member does not return before the bed hold expires, the Member will be discharged from LTC Facility in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

C. Transition from a Health Network to CalOptima's Long Term Care services upon termination of a Member's Skilled Nursing Facility (SNF) Covered Services for CalOptima ~~m~~Members with Medicare coverage:

1. A Health Network shall notify the SNF and the CalOptima LTSS Department upon issuing the Notice of Medicare Non-Coverage (NOMNC).

2. A Health Network shall submit a copy of the NOMNC, by facsimile, to the CalOptima LTSS Department upon issuing the notice, in accordance with CalOptima Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage. The CalOptima LTSS Department shall review the document during the LTC authorization review process.

3. The ~~f~~Facility shall submit an LTC Authorization Request Form (ARF) to CalOptima's LTSS Department in accordance with CalOptima policy.

D. Transition of care from skilled short stay to LTC custodial care (CalOptima Medi-Cal Only Members Assigned to Health Networks or Kaiser) shall include:

1. MD order; and

2. LTC ARF submitted to CalOptima's LTSS Department, in accordance with CalOptima policy.

a) A denial letter from skilled short stay to LTC is not required.

E. An LTC F~~f~~acility may modify a CalOptima Member's level of care or coordinate a Member's discharge from the LTC F~~f~~acility, with appropriate physician signature approval, if the following specified circumstances are present:

1. The LTC F~~f~~acility is no longer capable of meeting the Member's health care needs;

2. The Member's health has improved sufficiently, so that the Member no longer needs nursing facility services; or

3. The Member poses a risk to the health or safety of individuals in the facility.

F. When one (1) of the circumstances in Section II.E, above, presents itself, the LTC F~~f~~acility shall arrange and coordinate with CalOptima or a Health Network to discharge the CalOptima Member to the appropriate setting, including to the community with referrals for Home and Community-Based Services (HCBS), as appropriate.

III. PROCEDURE

A. Transfer from an acute care f~~F~~acility to an LTC Facility

1. Upon determination by the acute care f~~F~~acility attending physician and the ICT that a Member meets the criteria for transfer to an LTC Facility, the attending physician shall write an order for transfer to an LTC Facility of the appropriate Level of Care.

2. The hospital discharge planner shall work with the ~~m~~Member, ~~m~~Member's family, CalOptima, the Member's Health Network, or RCOC, as appropriate, to find placement in a CalOptima-contracted LTC Facility.

3. The acute care facility shall collaborate with all appropriate ICT staff to facilitate the transfer including, but not limited to, a CalOptima representative, a Health Network representative, a Primary Care Practitioner (PCP), the attending physician, hospital discharge planner, ancillary service providers, and outside agencies (e.g., RCOC, Orange County Behavioral Health Services (OCBHS).

4. Upon identification of an accepting LTC Facility, the hospital discharge planner shall coordinate the transfer, including transportation and Ancillary Services, with the physician, ~~m~~Member, ~~m~~Member's family, f~~F~~acility, CalOptima, the Member's Health Network, RCOC, and OCBHS, as appropriate.

5. Upon a Member's admission to an LTC Facility, the LTC Facility shall notify the CalOptima LTSS Department of the admission within twenty-one (21) calendar days after admission, or twenty-one (21) calendar days after CalOptima becomes financially responsible for the Member's admission, whichever is later.

B. Planned transfer from an LTC Facility to an acute care facility

1. Upon determination by the LTC Facility that a Member requires a planned admission to an acute care f~~F~~acility, the Member's attending physician shall obtain authorization for the acute care admission from CalOptima, or the Member's Health Network, ~~or CCS,~~ as appropriate.

2. The attending physician shall initiate the discharge planning orders and inter-facility transfer orders.

3. The LTC Facility shall coordinate the transfer, including transportation and ancillary services, with the physician, ~~m~~Member, ~~m~~Member's family, f~~F~~acility, CalOptima, the Member's Health Network, RCOC, and OCBHS, as appropriate.

4. The LTC Facility shall verify with the Member, the Member's Authorized Representative, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the LTC Facility shall hold the bed for the Member, in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

5. Upon admission to the acute care facility, the acute care facility shall notify CalOptima~~,~~ or the Member's Health Network of the admission, as appropriate.

C. Urgent or emergent transfer from an LTC Facility to an acute care f~~F~~acility

1. Upon an LTC Facility identification of a Member requiring emergent acute care admission, the LTC Facility shall call for 911 transport of the Member.

2. The LTC Facility shall notify the attending physician of the urgent transfer and the attending physician shall order the 911 transfer.

3. The LTC Facility shall verify with the Member, the Member's Authorized Representative, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the LTC Facility shall hold the bed for the Member, in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

D. Transition from a Health Network skilled nursing short-term stay to Long-Term Care (LTC)

1. If a Member no longer meets Medical Necessity criteria, or exhausts his or her Medicare SNF Covered Services, the Member will remain in the f~~F~~acility under the CalOptima LTC Medi-Cal benefit. The Nursing Facility shall notify CalOptima LTSS Department by using the LTC Authorization Request Form (ARF), including Notice of Medicare Non-Coverage (NOMNC) letter if applicable and MD order from the Member's ~~primary care physician (PCP)~~ or attending physician~~Health Network~~.

2. CalOptima shall review the authorization request and make a determination in accordance with CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B).

E. Transition from an LTC F~~f~~acility to a community setting

1. The LTC F~~f~~acility shall notify CalOptima or a Health Network of the Member's capacity and preference for discharging to a community setting as soon as the information is available to provide sufficient time to safely plan and coordinate the transition.

2. CalOptima or a health network shall work with the LTC F~~f~~acility to ensure that all Medically Necessary services are provided in a timely manner upon discharge, and the Member's transition to the most appropriate level of community-based care meets the Member's medical and social needs. The Member's medical needs, supports, and services throughout the transition and post-discharge period shall be coordinated and may include, but is not limited to:

a. Documentation of pre-admission, or baseline status;

b. Coordination with appropriate waiver and other specialized programs such as the California Community Transitions Project (CCT) or the Home and Community Based Alternative Waiver (HCBA) to support the Member during the transition and ensure adequacy of resources post-discharge;

c. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based LTSS programs;

d. Initial coordination of care, as appropriate with the member's caregiver, other agencies and healthcare personnel; and

e. Provision of information for making follow-up appointments.

3. The LTSS Department Staff shall make a referral to the Case Management Department or a Health Network, as appropriate, when the member is discharged from the LTC Ff~~f~~acility.

IV. ATTACHMENT(S)

A. CalOptima Long-Term Care (LTC) Authorization Request Form (ARF)

V. REFERENCE(S)

A. Californian Children Services and CalOptima Memorandum of Understanding
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy EE.1135: Long-Term Care Ff~~f~~acility Contracting
D. CalOptima Policy GG.1505: Transportation, Emergency, Non-E~~e~~mergency and Non-Medical
E. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Ff~~f~~acility Level A (NF-A) and Nursing Ff~~f~~acility Level B (NF-B)
F. CalOptima Policy GG.1810: Bed Hold, Long-Term Care
G. CalOptima Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage
H. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. CalOptima Utilization Management Plan
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements For Nursing Ff~~f~~acility Services In Coordinated Care Initiative Counties For Beneficiaries Not Enrolled In Cal MediConnect.
K. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing Ff~~f~~acility Services.
~~J.~~L. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
~~K.~~M. Long-Term Care Ff~~f~~acility Agreement
~~L.~~N. Regional Center of Orange County and CalOptima Memorandum of Understanding
~~M.~~O. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 76079, 76345 and 76853
~~N.A. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing facility Services.~~
~~O.A. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements For Nursing facility Services In Coordinated Care Initiative Counties For Beneficiaries Not Enrolled In Cal MediConnect.~~

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1999	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long- Term Care Facilities	Medi-Cal
Effective	08/01/2005	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare
Revised	04/01/2007	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long- Term Care Facilities	Medi-Cal
Revised	02/01/2016	GG.1822	Process for Transferring CalOptima Member between Acute Care Facilities to Long- Term Care	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1822	Process for Transferring CalOptima Members between Care Facilities	Medi-Cal OneCare Connect
Retired	10/11/2016	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare
Revised	11/01/2017	GG.1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect
Revised	12/05/2019	GG. 1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect
Revised	TBD	GG. 1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect

IX. GLOSSARY

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Authorized Representative	Medi-Cal: A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009: Access by a Member's Authorized Representative.~~. OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
~~CalOptima~~	~~For the purposes of this policy, CalOptima shall include CalOptima Community Network (CNN).~~
~~CalOptima Community Network (CCN)~~	~~A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.CalOptima's own health network created to improve care management for their Members and physicians.~~
Community-Based Adult Services (CBAS)	Medi-Cal: An outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91, to eligible Members who meet applicable eligibility criteria~~, to eligible Members who meet applicable eligibility criteria.~~. OneCare Connect: Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family / caregiver training and support, nutrition services, and transportation to eligible beneficiaries, aged 18 years and older, blind, or disabled.

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program ~~effective July 1, 2019~~, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), ~~effective January 1, 2020~~ for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~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 Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
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.
Home and Community-Based Services (HCBS)	Home and Community-Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individualized Plan of Care.
Level of Care (LOC)	Criteria for determining admission to a LTC F~~f~~acility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.

Term	Definition
Long-Term Care (LTC)	For purposes of this policy, care provided for Members in a Skilled Nursing Ffacility and subacute care services.
Long-Term Care Ffacility	For the purposes of this policy, includes a Nursing Ffacility Level A (NF-A) [Intermediate Care Ffacility (ICF) or Subacute ffacility] and Nursing Ffacility Level B (NF-B) [Skilled Nursing Ffacility (SNF)].
Long-Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 1.2. Community-Based Adult Services (CBAS); 2.3. Multipurpose Senior Services Program (MSSP) services; and 3.4. Skilled nursing facility services and subacute care services.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).~~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.~~ OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A~~n enrollee~~ ~~Member~~ beneficiary enrolled in ~~of~~ a CalOptima program.
Notice of Medicare Non-Coverage (NOMNC)	A document that informs Members when their Medicare covered service(s) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).
Nursing Facility Level A (NF-A)	Known as the Immediate Care level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.

Term	Definition
Nursing Facility Level B (NF-B)	Known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
Primary Care Practitioner/Physician (PCP)	A Practitioner/physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model Program, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist physician~~Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a N~~n~~on-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, P~~p~~hysician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Chile Model beneficiaries, a PCP may also be a ~~specialist~~ Specialty Care Provider or clinic. ~~in accordance with W & I Code 14182(b) (11).~~
Skilled Nursing F~~f~~acility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.

Policy:	GG.1822
Title:	**Process for Transitioning CalOptima Members between Levels of Care**
Department:	Medical Management
Section:	Long-Term Services and Supports
CEO Approval:	
Effective Date:	03/01/1999
Revised Date:	

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy outlines the process for transitioning CalOptima Members between Levels of Care (LOC), as well as into and out of Long-Term Care (LTC).

II. POLICY

A. Transfer from an acute care facility to a Long-Term Care (LTC) Facility

1. The discharge planning process from the acute setting shall include a review of the Member's ability to be discharged to a community setting with referrals to Home and Community-Based Services (HCBS) and other waiver programs prior to transferring to an LTC Facility.

2. The acute care facility shall be responsible for all discharge planning aspects of a Member's transfer to an LTC Facility.

3. CalOptima, or a Health Network, may assist in coordinating the discharge planning of a Member from an acute care facility to an LTC Facility.

4. The acute care facility shall collaborate with all appropriate Interdisciplinary Care Team (ICT) staff to facilitate the transfer of the Member.

5. The admitting LTC Facility shall coordinate the medical and ancillary services with CalOptima, the Member's Health Network, and other appropriate agencies such as the Regional Center of Orange County (RCOC), as appropriate.

6. CalOptima or the Member's Health Network shall be responsible for a Member's transportation from an acute care facility to an LTC Facility, in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

B. Transfer from an LTC Facility to an acute care facility

1. An LTC Facility shall be responsible for coordinating a planned, emergent, or urgent transfer of a Member to an acute care facility.

Back to Agenda Back to Item

2. An LTC Facility shall collaborate with all appropriate ICT staff to facilitate either a planned, emergent, or urgent transfer of a Member from an LTC Facility to an acute care facility.

3. The LTC Facility shall submit a Bed Hold payment request to the CalOptima Claims Department with appropriate Bed Hold accommodation codes for LTC level of care and Bed Hold dates of service.

4. CalOptima or the Member's Health Network shall be responsible for a Member's transportation from an LTC facility to an acute care Facility, in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

5. Nursing facility may request a bed hold while a Member is in the acute setting. If a Member does not return before the bed hold expires, the Member will be discharged from LTC Facility in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

C. Transition from a Health Network to CalOptima's Long Term Care services upon termination of a Member's Skilled Nursing Facility (SNF) Covered Services for CalOptima Members with Medicare coverage:

1. A Health Network shall notify the SNF and the CalOptima LTSS Department upon issuing the Notice of Medicare Non-Coverage (NOMNC).

2. A Health Network shall submit a copy of the NOMNC, by facsimile, to the CalOptima LTSS Department upon issuing the notice, in accordance with CalOptima Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage. The CalOptima LTSS Department shall review the document during the LTC authorization review process.

3. The facility shall submit an LTC Authorization Request Form (ARF) to CalOptima's LTSS Department in accordance with CalOptima policy.

D. Transition of care from skilled short stay to LTC custodial care (CalOptima Medi-Cal Only Members Assigned to Health Networks or Kaiser) shall include:

1. MD order; and

2. LTC ARF submitted to CalOptima's LTSS Department, in accordance with CalOptima policy.

a) A denial letter from skilled short stay to LTC is not required.

E. An LTC Facility may modify a CalOptima Member's level of care or coordinate a Member's discharge from the LTC Facility, with appropriate physician signature approval, if the following specified circumstances are present:

1. The LTC Facility is no longer capable of meeting the Member's health care needs;

2. The Member's health has improved sufficiently, so that the Member no longer needs nursing facility services; or

3. The Member poses a risk to the health or safety of individuals in the facility.

F. When one (1) of the circumstances in Section II.E, above, presents itself, the LTC Facility shall arrange and coordinate with CalOptima or a Health Network to discharge the CalOptima Member to the appropriate setting, including to the community with referrals for Home and Community-Based Services (HCBS), as appropriate.

III. PROCEDURE

A. Transfer from an acute care facility to an LTC Facility

1. Upon determination by the acute care facility attending physician and the ICT that a Member meets the criteria for transfer to an LTC Facility, the attending physician shall write an order for transfer to an LTC Facility of the appropriate Level of Care.

2. The hospital discharge planner shall work with the Member, Member's family, CalOptima, the Member's Health Network, or RCOC, as appropriate, to find placement in a CalOptima-contracted LTC Facility.

3. The acute care facility shall collaborate with all appropriate ICT staff to facilitate the transfer including, but not limited to, a CalOptima representative, a Health Network representative, a Primary Care Practitioner (PCP), the attending physician, hospital discharge planner, ancillary service providers, and outside agencies (e.g., RCOC, Orange County Behavioral Health Services (OCBHS).

4. Upon identification of an accepting LTC Facility, the hospital discharge planner shall coordinate the transfer, including transportation and Ancillary Services, with the physician, Member, Member's family, facility, CalOptima, the Member's Health Network, RCOC, and OCBHS, as appropriate.

5. Upon a Member's admission to an LTC Facility, the LTC Facility shall notify the CalOptima LTSS Department of the admission within twenty-one (21) calendar days after admission, or twenty-one (21) calendar days after CalOptima becomes financially responsible for the Member's admission, whichever is later.

B. Planned transfer from an LTC Facility to an acute care facility

1. Upon determination by the LTC Facility that a Member requires a planned admission to an acute care facility, the Member's attending physician shall obtain authorization for the acute care admission from CalOptima, or the Member's Health Network, as appropriate.

2. The attending physician shall initiate the discharge planning orders and inter-facility transfer orders.

3. The LTC Facility shall coordinate the transfer, including transportation and ancillary services, with the physician, Member, Member's family, facility, CalOptima, the Member's Health Network, RCOC, and OCBHS, as appropriate.

4. The LTC Facility shall verify with the Member, the Member's Authorized Representative, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the LTC Facility shall hold the bed for the Member, in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

5. Upon admission to the acute care facility, the acute care facility shall notify CalOptima or the Member's Health Network of the admission, as appropriate.

C. Urgent or emergent transfer from an LTC Facility to an acute care facility

1. Upon an LTC Facility identification of a Member requiring emergent acute care admission, the LTC Facility shall call for 911 transport of the Member.

2. The LTC Facility shall notify the attending physician of the urgent transfer and the attending physician shall order the 911 transfer.

3. The LTC Facility shall verify with the Member, the Member's Authorized Representative, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the LTC Facility shall hold the bed for the Member, in accordance with CalOptima Policy GG.1810: Bed Hold, Long-Term Care.

D. Transition from a Health Network skilled nursing short-term stay to Long-Term Care (LTC)

1. If a Member no longer meets Medical Necessity criteria, or exhausts his or her Medicare SNF Covered Services, the Member will remain in the facility under the CalOptima LTC Medi-Cal benefit. The Nursing Facility shall notify CalOptima LTSS Department by using the LTC Authorization Request Form (ARF), including Notice of Medicare Non-Coverage (NOMNC) letter if applicable and MD order from the Member's PCP or attending physician.

2. CalOptima shall review the authorization request and make a determination in accordance with CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B).

E. Transition from an LTC Facility to a community setting

1. The LTC Facility shall notify CalOptima or a Health Network of the Member's capacity and preference for discharging to a community setting as soon as the information is available to provide sufficient time to safely plan and coordinate the transition.

2. CalOptima or a health network shall work with the LTC Facility to ensure that all Medically Necessary services are provided in a timely manner upon discharge, and the Member's transition to the most appropriate level of community-based care meets the Member's medical and social needs. The Member's medical needs, supports, and services throughout the transition and post-discharge period shall be coordinated and may include, but is not limited to:

a. Documentation of pre-admission, or baseline status;

b. Coordination with appropriate waiver and other specialized programs such as the California Community Transitions Project (CCT) or the Home and Community Based Alternative Waiver (HCBA) to support the Member during the transition and ensure adequacy of resources post-discharge;

c. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based LTSS programs;

d. Initial coordination of care, as appropriate with the member's caregiver, other agencies and healthcare personnel; and

e. Provision of information for making follow-up appointments.

3. The LTSS Department Staff shall make a referral to the Case Management Department or a Health Network, as appropriate, when the member is discharged from the LTC Facility.

IV. ATTACHMENT(S)

A. CalOptima Long-Term Care (LTC) Authorization Request Form (ARF)

V. REFERENCE(S)

A. Californian Children Services and CalOptima Memorandum of Understanding
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy EE.1135: Long-Term Care Facility Contracting
D. CalOptima Policy GG.1505: Transportation, Emergency, Non-Emergency and Non-Medical
E. CalOptima Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B)
F. CalOptima Policy GG.1810: Bed Hold, Long-Term Care
G. CalOptima Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage
H. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
I. CalOptima Utilization Management Plan
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements For Nursing Facility Services In Coordinated Care Initiative Counties For Beneficiaries Not Enrolled In Cal MediConnect.
K. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing Facility Services.
L. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
M. Long-Term Care Facility Agreement
N. Regional Center of Orange County and CalOptima Memorandum of Understanding
O. Title 22, California Code of Regulations (CCR), §§ 51121, 51212, 51215, 51215.5, 51215.8, 76079, 76345 and 76853

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1999	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long- Term Care Facilities	Medi-Cal
Effective	08/01/2005	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare
Revised	04/01/2007	GG.1822	Process for Transferring CalOptima Members between Acute Care Facilities to Long- Term Care Facilities	Medi-Cal
Revised	02/01/2016	GG.1822	Process for Transferring CalOptima Member between Acute Care Facilities to Long- Term Care	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1822	Process for Transferring CalOptima Members between Care Facilities	Medi-Cal OneCare Connect
Retired	10/11/2016	MA.6018	Member Transfer from Skilled Nursing Long-Term Care	OneCare
Revised	11/01/2017	GG.1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect
Revised	12/05/2019	GG. 1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect
Revised	TBD	GG. 1822	Process for Transferring CalOptima Members between Levels of Care	Medi-Cal OneCare Connect

1

IX. GLOSSARY

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Authorized Representative	Medi-Cal: A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors. OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
Community-Based Adult Services (CBAS)	Medi-Cal: An outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91, to eligible Members who meet applicable eligibility criteria. OneCare Connect: Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family / caregiver training and support, nutrition services, and transportation to eligible beneficiaries, aged 18 years and older, blind, or disabled.

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
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.
Home and Community-Based Services (HCBS)	Home and Community-Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individualized Plan of Care.
Level of Care (LOC)	Criteria for determining admission to a LTC Facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.
Long-Term Care (LTC)	For purposes of this policy, care provided for Members in a Skilled Nursing Facility and subacute care services.
Long-Term Care Facility	For the purposes of this policy, includes a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF)].

Term	Definition
Long-Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. In-Home Supportive Services (IHSS); 2. Community-Based Adult Services (CBAS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v). OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A beneficiary enrolled in a CalOptima program.
Notice of Medicare Non-Coverage (NOMNC)	A document that informs Members when their Medicare covered service(s) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).
Nursing Facility Level A (NF-A)	Known as the Immediate Care level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model Program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Chile Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Skilled Nursing Facility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.

1

CalOptima
A Public Agency
Better. Together.

P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Pending
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ **Bed Hold End Date:** _____
Bed Hold Start Date: _____ **Bed Hold End Date:** _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

PROVIDER: Authorization does not guarantee payment. CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ (Last) _____ (First) ☐ M ☐ F **D.O.B.** _____ **Age:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ **SNF** ☐ **ICF** ☐ **ICFDD** ☐ **ICFDDN** ☐ **ICFDDH** ☐ **SUBACUTE-VENT** ☐ **SUBACUTE-NON-VENT**

SECTION II Admitted From:
- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:
- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes
- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Actions Related to Payments to and Contract Terms with the Children's Hospital of Orange County Physician-Hospital Consortium Health Network

Contact

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

Recommended Actions

1. Authorize monthly transitional supplemental payments to Children's Hospital of Orange County (CHOC) in an amount of up to $160,000 for the months of September 2020 through June 2021, for a total amount not to exceed $1.6 million;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment to the CHOC Physician-Hospital Consortium hospital contract reflecting these monthly supplemental transition payments; and
3. Make a finding that the transitional supplemental payments are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Background & Discussion

CHOC contracts with CalOptima as a Physician-Hospital Consortium (PHC) Health Network comprised of Children's Hospital of Orange County (CHOC) and the CHOC Physicians Network. On June 4, 2020, the CalOptima Board of Directors approved an extension of contracts for Fiscal Year (FY) 2020-21, for all Medi-Cal Health Networks including the CHOC pediatric Health Network. The extension was authorized through June 30, 2021 and included terms reflecting adjusted capitation rates following CalOptima's periodic rebasing process. However, CHOC management expressed concerns about the rebasing process and the new capitation rates, specifically that the new rebased rates did not take into account the special nature of CHOC's pediatric-only PHC model. Furthermore, CHOC suggested that a review period was needed to allow additional time for examination and analysis of utilization data to verify whether CalOptima's rebased capitation rates were applicable to CHOC as they are across all other Medi-Cal Health Networks.

The CHOC PHC contracts were extended through June 30, 2021, and, as ratified by the Board at its August 6, 2020 meeting, a 60 day review period (July and August 2020) was included to allow CHOC additional time for data collection and analysis, and to allow for further discussion about the new capitation rates with CalOptima staff. The contract provides that during this review period, rebased payments under the CHOC PHC hospital contract are to be supplemented to bring them to approximately the equivalent of the pre-rebased rates.

During the review period, staff from CalOptima and CHOC have worked collaboratively to look at additional data and analyze CalOptima's rebased rates as they apply to CHOC. Based on these meetings, CalOptima and CHOC have agreed that the encounter data as presented to Milliman, shows no material differences and no basis to dispute the rebasing methodology or applicability of the rebased rate. As a network focused strictly on the pediatric member population, CHOC has been part of

Back to Agenda

CalOptima's Medi-Cal health network since its inception in 1995, accommodating the ever-evolving needs of CalOptima's pediatric member population. Most recently, this has included being a major partner in providing specialized pediatric healthcare in Orange County for the Whole Child Model. CHOC is the only safety net hospital of its kind in Orange County, serving as a critical component of the health care delivery system serving CalOptima's 350,000 pediatric Medi-Cal members. Because CHOC does not generate charges and receive payments for services rendered to adult members that could offset capitation rate decreases for pediatric members, the Board-approved rebased cuts are significantly higher for CHOC by comparison with CalOptima's other Medi-Cal health networks. As such, management believes that providing supplemental transition payments to mitigate this disparity is reasonable and recommends that the Board approve the continuation of supplemental transition payments totaling $1.6 million ($160,000 per month) between September 1, 2020 and June 30, 2021, and amending the CHOC Hospital PHC contract to reflect these payments. This should provide sufficient time for CHOC to amend provider contracts and make other changes to its program or operation, and there is no expectation that supplemental transition payments will continue beyond June 30, 2021.

Fiscal Impact

The recommended action to authorize supplemental transition payments and execute a contract amendment with CHOC reflecting monthly supplemental transition payments of $160,000 from September 1, 2020 through June 30, 2021, is unbudgeted. An allocation of up to $1.6 million from existing reserves will fund this recommended action.

Rationale for Recommendation

Through retention of CHOC as a Physician-Hospital Consortium, CalOptima ensures continuity of access to highly specialized pediatric provider services for the pediatric Medi-Cal population we serve.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated August 6, 2020; "Consider Ratification of Amendment to Health Network Contract with Children's Hospital of Orange County and Authorization of Related Funding"
3. Previous Board Action dated June 4, 2020; "Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts"

/s/ Richard Sanchez — *8/26/2020*
Authorized Signature — **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Children's Hospital of Orange County and CHOC Physicians Network	1120 West La Veta Avenue, Ste. 450	Orange	CA	92868

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Ratify amendment to the Children's Hospital of Orange County's Health Network Hospital Contract (Hospital Contract Amendment) incorporating a 60-day review period of the rebased capitation rates (Review Period) and the continuation of pre-amendment base rates through the use of supplemental payments for such Review Period;
2. Authorize unbudgeted expenditures of up to $2.4 million from existing reserves for the Hospital Contract Amendment Review Period supplemental payments; and
3. Make a finding that such Review Period supplemental expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Background/Discussion

One of CalOptima's networks is a Physician-Hospital Consortium (PHC) comprised of Children's Hospital of Orange County (CHOC) and the CHOC Physicians Network. As with CalOptima's 11 other Medi-Cal Health Networks, CalOptima contracts with the CHOC PHC on a fixed term basis. Any extensions or renewals of the Health Network contracts are subject to Board approval and made through amendments to the Health Network Contracts. The CalOptima Board of Directors approved an extension for Fiscal Year (FY) 2020-21 on June 4, 2020 for all Medi-Cal Health Networks, including the CHOC pediatric Health Network. The extension was authorized through June 30, 2021. That authorization also included changes to the administration of directed payments and incorporation of rebased capitation payment rates for hospital services.

Upon receiving the amendment to its contract, CHOC expressed concerns that the rebasing process did not take into account the special nature of its pediatric-only PHC model and the adequacy of the new capitation rates. In order to allow additional time for CHOC to validate the data and submit additional analysis for further discussion of the rebased capitation rates, the parties agreed to include a 60-day review period in the amendment. CalOptima staff also agreed, subject to Board approval, that CHOC would continue to receive compensation equivalent to the variance between the pre-amendment base rates and the new base rates, both subject to the application of updated member risk adjustment factors effective July 1, 2020, through supplemental payments for the duration of the Review Period.

While the contract extension was signed by CHOC on June 30, 2020, to ensure continuity of member care, the Review Period is needed to allow additional time for CHOC to provide additional data/ analysis in order for CalOptima to ensure that current hospital capitation rates for the Medi-Cal Classic population are consistent with CalOptima's rebasing principles applicable to all capitated Health Networks.

Back to Agenda Back to Item

Staff from CalOptima and CHOC are working collaboratively to review any additional data or analysis that would impact the Medi-Cal rates. In the event that CalOptima and CHOC are unable to come to agreement on mutually agreeable rates by August 31, 2020, either party may provide notice of termination pursuant to the terms of the CHOC Contract. If it is determined that a higher capitation rate is warranted for the CHOC PHC hospital contract under CalOptima's rebasing principles, staff will return to the Board with recommendations regarding any proposed adjustments to those capitation rates.

For the Review Period of July 1, 2020 through August 31, 2020, CalOptima will provide CHOC Hospital with supplemental payments. The supplemental payments coupled with the rebased payments are intended to provide CHOC with funding at approximately the FY 2019-20 base rates through the 60-day Review Period. The estimated Review Period supplemental payment will equal the difference between the new base rates set forth in Attachment E of the FY 2020-21 executed amendment, and the previous base rates set forth in Attachment E of the Amended and Restated Contract with the updated member risk adjustment factors effective July 1, 2020. In the event of a termination, CHOC would be entitled to retain the supplemental payments received for the Review Period.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Fiscal Impact
The recommended action to ratify the Hospital Contract Amendment and authorize supplemental payment expenditures during the July 1, 2020 to August 31, 2020 Review Period is unbudgeted. An allocation of up to $2.4 million from existing reserves will fund this action.

Rationale for Recommendation
Providing the Review Period will allow CHOC time to provide additional rate-related data and/or analysis in order for CalOptima to ensure that the FY2020-21 capitation rates are consistent with CalOptima's rebasing principles.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated June 4, 2020; "Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts"

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

Back to Agenda Back to Item

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Children's Hospital of Orange County and CHOC Physicians Network	1120 West La Veta Avenue, Ste. 450	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contact
Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion
CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

Back to Agenda Back to Item

Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions

Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact

The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

Back to Agenda Back to Item

emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

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

5/29/2019 — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

Back to Agenda Back to Item

Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

~~1. Michael Arnot for a two-year term ending June 30, 2020;~~
~~2. Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
~~3. Gabriela Huerta for a two-year term ending June 30, 2020; and~~
~~4. Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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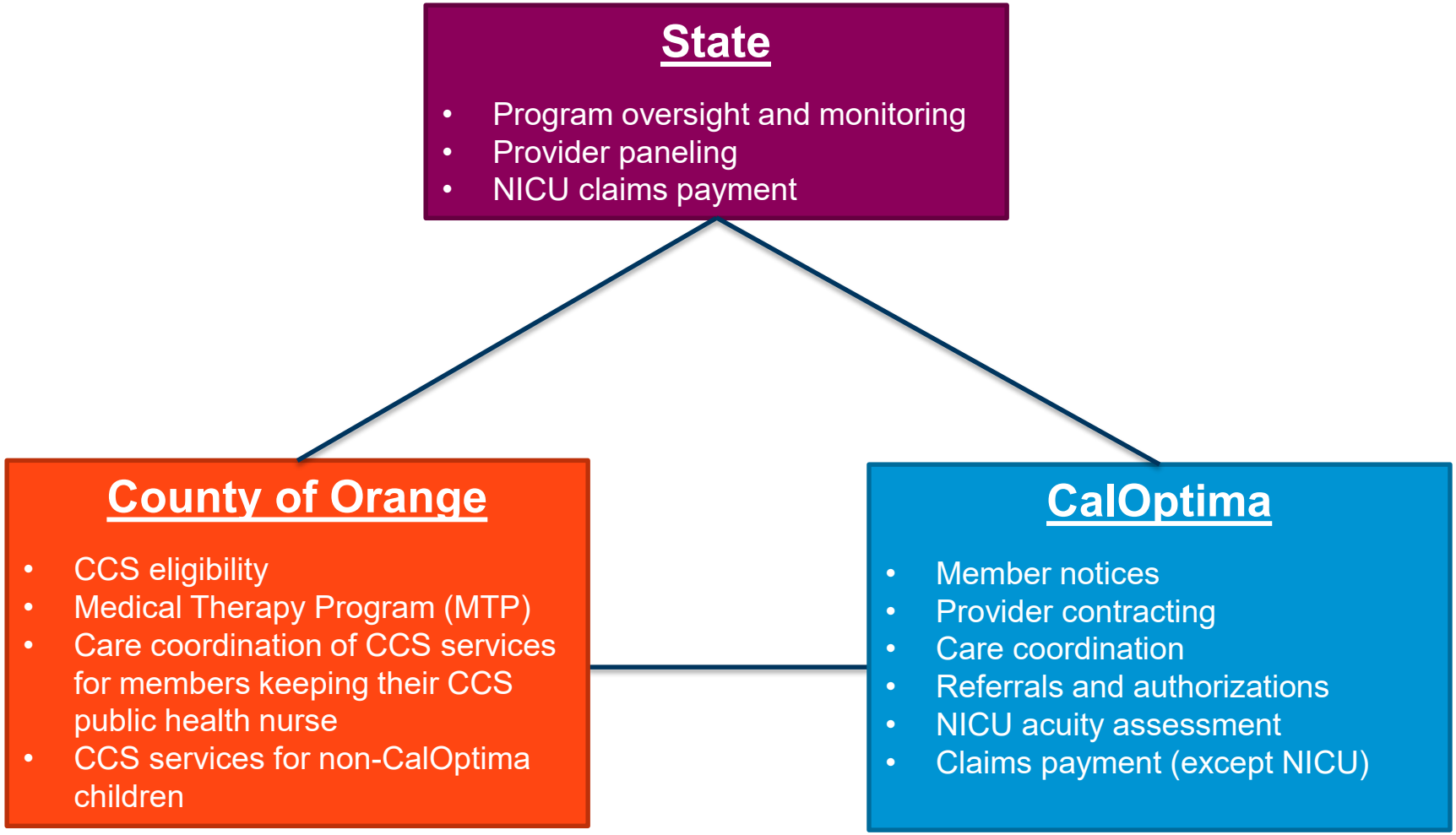
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - ➢ All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - ➢ Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	
Include relevant experience with these populations	1–5	
3. Knowledge or experience with California Children's Services	1–5	
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	
6. Ability to speak one of the threshold languages (other than English)	Yes/No	
7. Availability and willingness to attend meetings	Yes/No	
8. Supportive references	Yes/No	
	Total Possible Points	30
	Total Points Awarded	

_____
Name of Evaluator

Back to Agenda Back to Item

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

Back to Agenda Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

Back to Agenda Back to Item

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

Back to Agenda Back to Item

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.

Back to Agenda Back to Item

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

~~1. Michael Arnot for a two-year term ending June 30, 2020;~~
~~2. Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
~~3. Gabriela Huerta for a two-year term ending June 30, 2020; and~~
~~4. Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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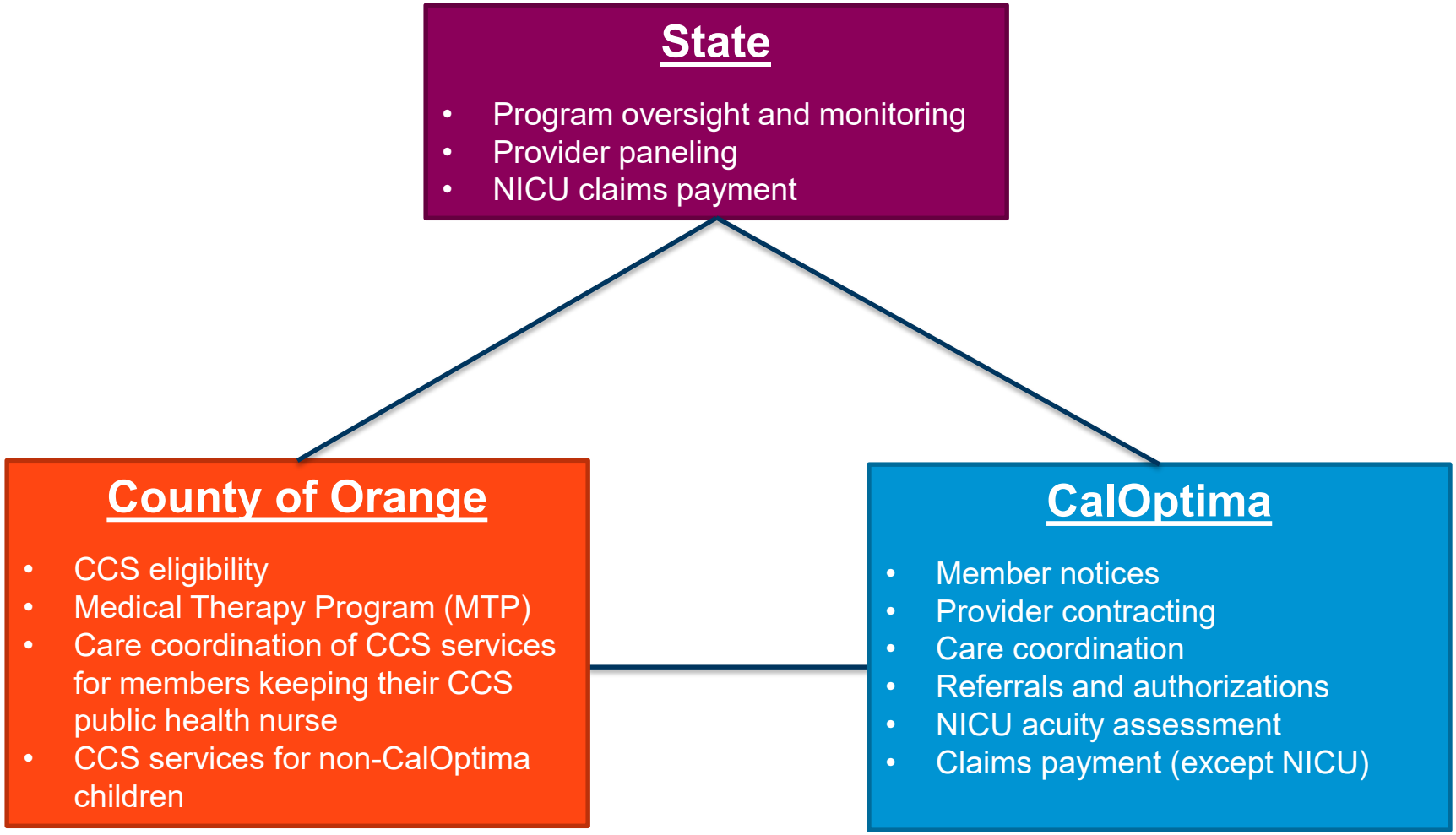
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - ➢ All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - ➢ Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	
Include relevant experience with these populations	1–5	
3. Knowledge or experience with California Children's Services	1–5	
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	
6. Ability to speak one of the threshold languages (other than English)	Yes/No	
7. Availability and willingness to attend meetings	Yes/No	
8. Supportive references	Yes/No	
	Total Possible Points	30
	Total Points Awarded	

_____
Name of Evaluator

Back to Agenda Back to Item

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

Back to Agenda Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

Back to Agenda Back to Item

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

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact

The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

Back to Agenda Back to Item

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

   a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

   b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

   a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

      i. The Member has other sources of health coverage;

      ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

      iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

      iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

   a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

   a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

   b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Back to Agenda Back to Item

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Back to Agenda Back to Item

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

Back to Agenda Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

Back to Agenda Back to Item

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.,* based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.,* between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

   c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.,* Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

Back to Agenda Back to Item

III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

Discussion

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

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

Back to Agenda Back to Item

DHCS/Kaiser/Plan Agreement

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

The three-way agreement includes the following provisions:

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

Kaiser/Plan Agreement

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

The two-way agreement includes the following provisions:

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

Back to Agenda Back to Item

Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

Back to Agenda Back to Item

emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

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

5/29/2019 — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

Back to Agenda Back to Item

Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

Back to Agenda Back to Item

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

c. Current CalOptima members age of 21 and over who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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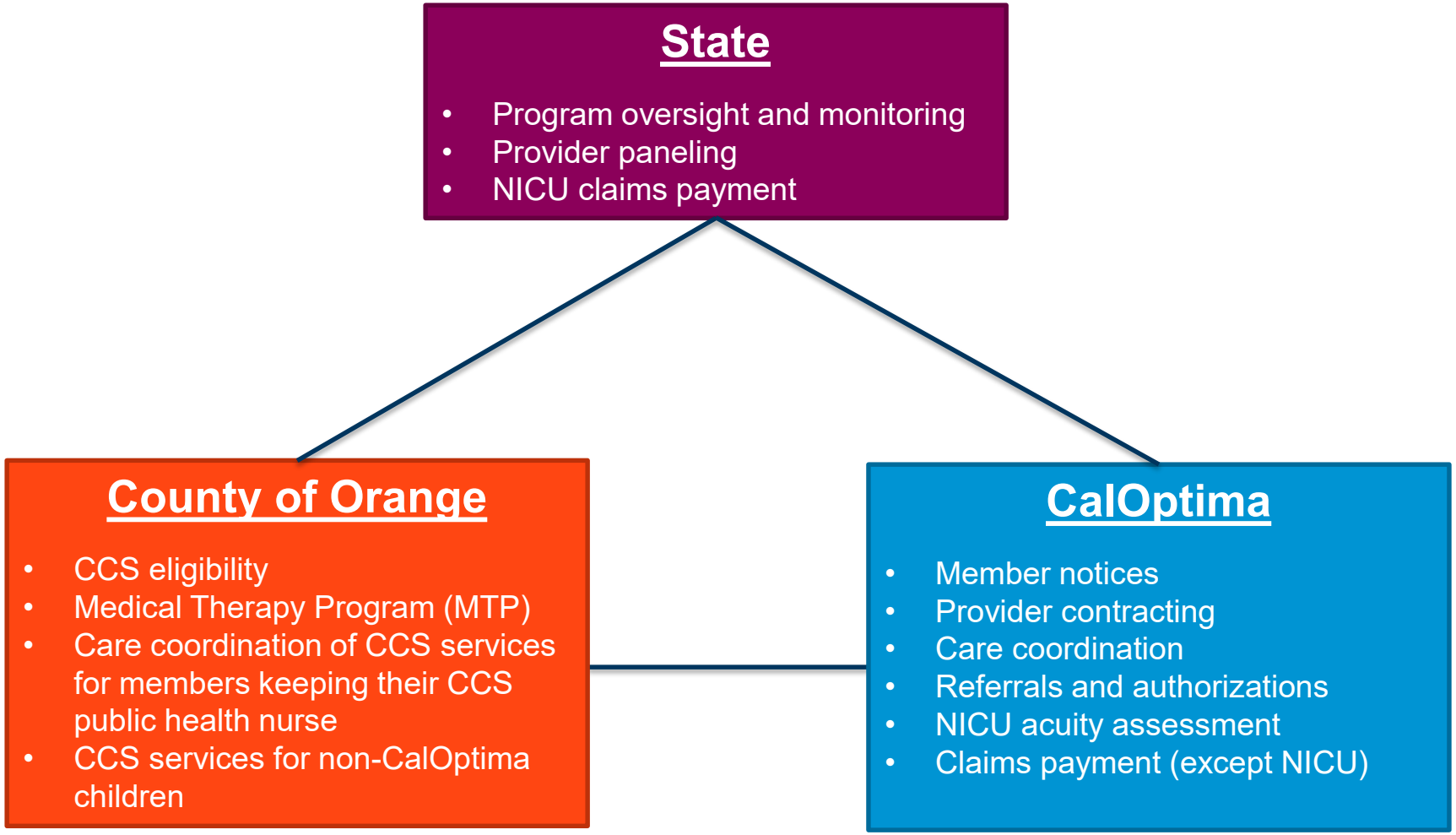
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - ➢ All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - ➢ Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD
MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	
Include relevant experience with these populations	1–5	
3. Knowledge or experience with California Children's Services	1–5	
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	
6. Ability to speak one of the threshold languages (other than English)	Yes/No	
7. Availability and willingness to attend meetings	Yes/No	
8. Supportive references	Yes/No	
	Total Possible Points	30
	Total Points Awarded	

_____
Name of Evaluator

Back to Agenda Back to Item

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

Back to Agenda Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

Back to Agenda Back to Item

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

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel. to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Modify the rebased capitation rates for the Medi-Cal Classic population, effective January 1, 2019, as authorized in a separate Board action;
2. Modify capitation rates effective January 1, 2019, to include rates associated with the Whole Child Model program to the extent authorized by the Board of Directors in a separate Board action;
3. Amend the contract terms to reflect applicable regulatory changes and other requirements associated with the Whole-Child Model (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

c. Current CalOptima members age of 21 and over who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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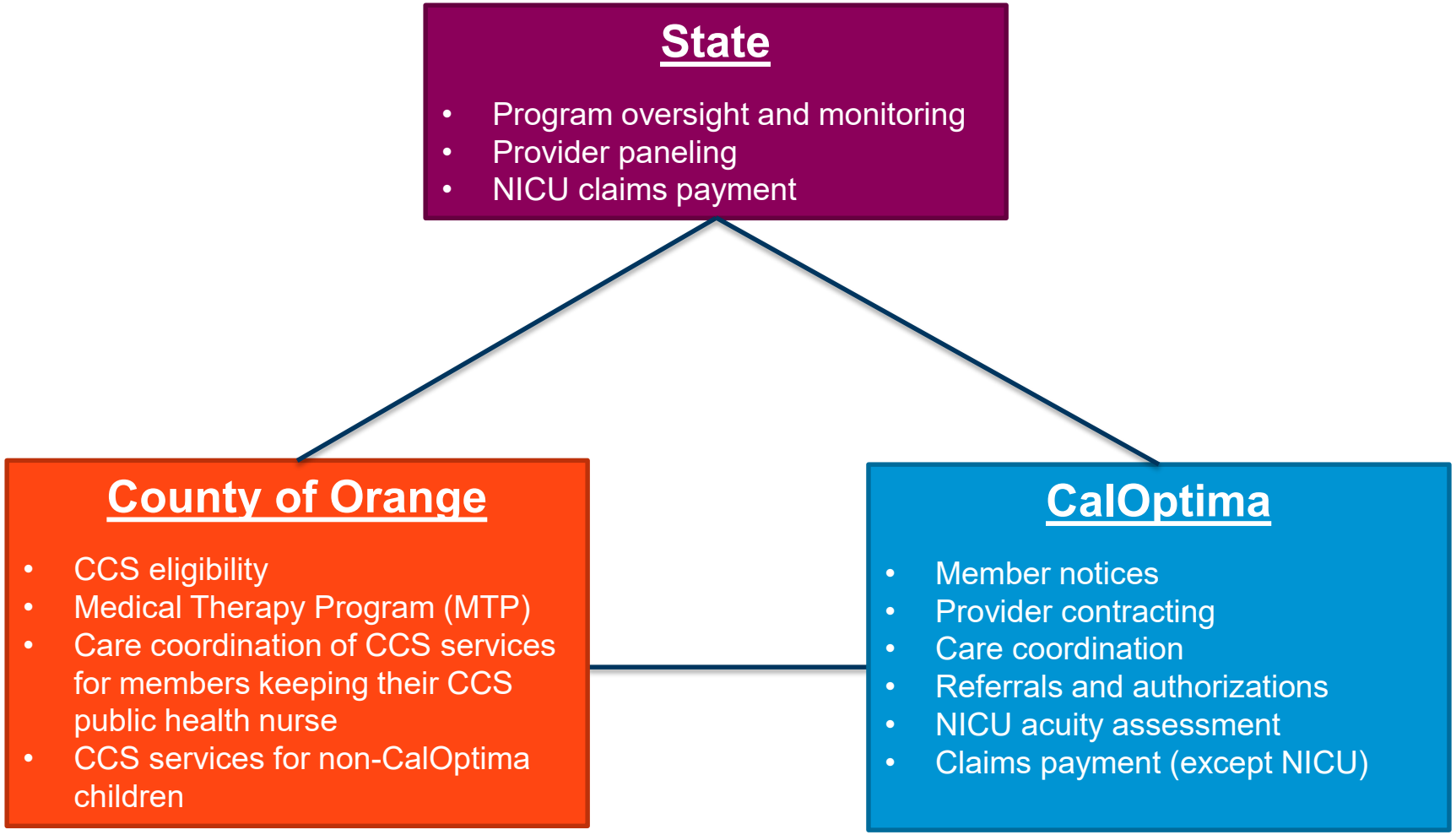
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - ➢ All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - ➢ Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD
MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	
Include relevant experience with these populations	1–5	
3. Knowledge or experience with California Children's Services	1–5	
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	
6. Ability to speak one of the threshold languages (other than English)	Yes/No	
7. Availability and willingness to attend meetings	Yes/No	
8. Supportive references	Yes/No	
	Total Possible Points	30
	Total Points Awarded	

_____
Name of Evaluator

Back to Agenda Back to Item

Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

Back to Agenda Back to Item

CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

Back to Agenda Back to Item

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

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact
The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

Back to Agenda Back to Item

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

   a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

   b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

   a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

      i. The Member has other sources of health coverage;

      ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

      iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

      iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

   a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

   a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

   b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

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

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Back to Agenda Back to Item

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

Back to Agenda Back to Item

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

Back to Agenda Back to Item

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.,* based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.,* between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

   c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.,* Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose of this Policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

Back to Agenda Back to Item

III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima's Contract for Health Care Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

Discussion

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

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

Back to Agenda Back to Item

DHCS/Kaiser/Plan Agreement

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

The three-way agreement includes the following provisions:

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

Kaiser/Plan Agreement

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

The two-way agreement includes the following provisions:

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

None

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Renewal of the Program of All-Inclusive Care for the Elderly Primary Care Provider (PCP) Incentive Program and Related Changes to PCP Contracts

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

Specific to CalOptima's Program of All-Inclusive Care for the Elderly (PACE), authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Renew the CalOptima PACE PCP Incentive Program, subject to applicable regulatory approvals;
2. Amend CalOptima's current PACE PCP contracts to renew the PACE PCP Incentive Program; and
3. Include the PACE PCP Incentive Program language in all future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members.

Background

PACE is a managed care service delivery model for frail elderly participants that integrates acute, chronic and long-term care for nursing home certified seniors. The goals of PACE are to help participants continue to live safely at home in the community for as long as possible and to maintain or improve their functional status. CalOptima PACE is the first PACE program offered to Orange County residents.

At its September 7, 2017 meeting, the Board authorized amendment of the physician services contract with the University of California, Irvine (UCI) to include the UCI PACE PCP Incentive Program. At that meeting, the Board also authorized submission of the PACE community-based physician waiver to allow members to continue to see their current PCPs while also participating in PACE (reference Attachment 1: Board Action dated September 7, 2017). This waiver was approved by the Centers for Medicare and Medicaid Services (CMS) in March 2018.

At its June 7, 2018, meeting, the Board authorized the revision of the UCI PACE PCP Incentive Program, subsequently renamed the PACE PCP Incentive Program, along with its expansion to all the PACE PCP contracts, including community-based PACE PCPs (reference Attachment 2: Board Action dated June 7, 2018).

At its August 1, 2019, meeting, the Board authorized the renewal of the PACE PCP Incentive Program with minor revisions to the quality improvement (QI) incentive of the Incentive Program (reference Attachment 3: Board Action dated August 1, 2019).

PCPs have traditionally provided both clinic and non-clinic-based care. Clinic-based services are those services rendered in an outpatient clinic, such as the PACE Center clinic. Non-clinic-based PCP services

Back to Agenda

are those provided outside of an outpatient clinic such as in an emergency room (ER), in the member's home, a nursing facility or hospital. Although it is less common to find community PCPs who provide both clinic and non-clinic-based care, it is common within PACE organizations.

The current PACE PCP Incentive Program includes both QI and utilization measures. The Incentive Program allows those PACE PCPs involved in non-clinic-based care to participate, including those involved with inpatient care, nursing facility care, home visits and after-hours on-call services. This has resulted in an increase in the number of after-hours and weekend home evaluations. These increased home visits were associated with a decrease in hospital admissions.

The current QI components of the Incentive Program are allocated up to $12.50 per member per month (PMPM) to the seven QI incentive measures. As a comparison, CalOptima's Community Care Network (CCN) allocates $20 PMPM for its OneCare Connect (OCC) program PCP incentives in Fiscal Year (FY) 2018–2019.

Discussion

CalOptima has a long history of incentivizing community partners who go above and beyond in the provision of care to our members. Including the PACE PCPs involved in non-clinic-based care has led to more after-hours and weekend home and telehealth evaluations, which has improved the quality of care, reduced inpatient utilization and promoted appropriate use of health care resources. These after-hours and weekend home and telehealth visits have taken on much greater importance since the onset of the COVID-19 pandemic as many PACE participants have been reluctant to come to the clinic to address their acute needs. This can lead to a delay in care, which can increase morbidity and mortality. The ability for the PACE PCPs involved in non-clinic-based care to perform on-demand, urgent after-hours and weekend home and telehealth evaluations has been invaluable during this challenging time. As a result, the hospital bed days have continued to decrease year over year since the Incentive Program began in 2017. Additionally, since the onset of the COVID-19 pandemic, we have seen a 98% increase in the number of after-hours/weekend telehealth evaluations and an 8% increase in the number of after-hours/weekend home visit evaluations completed by our on-call providers. Staff is proposing to continue the utilization management (UM) element of this Incentive Program for FY 2020–2021 and to maintain the same distribution methodology.

Staff is also proposing to continue the QI component of the PACE PCP Incentive Program as they have been shown to be very effective.

- Participant Satisfaction: In 2019, PACE saw a year over year improvement in seven of the 10 participant satisfaction survey domains, including the two QI participant satisfaction elements. Additionally, CalOptima PACE had the #1 overall satisfaction score of all California PACE programs and scored higher than the state and national averages on all 10 participant satisfaction domains.
- Comprehensive Diabetic Care: Maintained high annual diabetic eye exam, nephropathy monitoring and blood pressure control rates. Our 2019 rates were comparable to the 90th percentile of the 2018 HEDIS Medicare Quality Compass for blood pressure control and the 95th percentile for the annual diabetic eye exam and nephropathy monitoring.
- Potential Harmful Drug/Disease Interactions in the Elderly: Maintained a low rate of those

members with dementia who were on a tricyclic antidepressant or anticholinergic agent comparable to the 95th percentile of the 2018 Medicare Quality Compass.
Functional Status Assessment Completion: 100% of these assessments were completed in a timely manner.

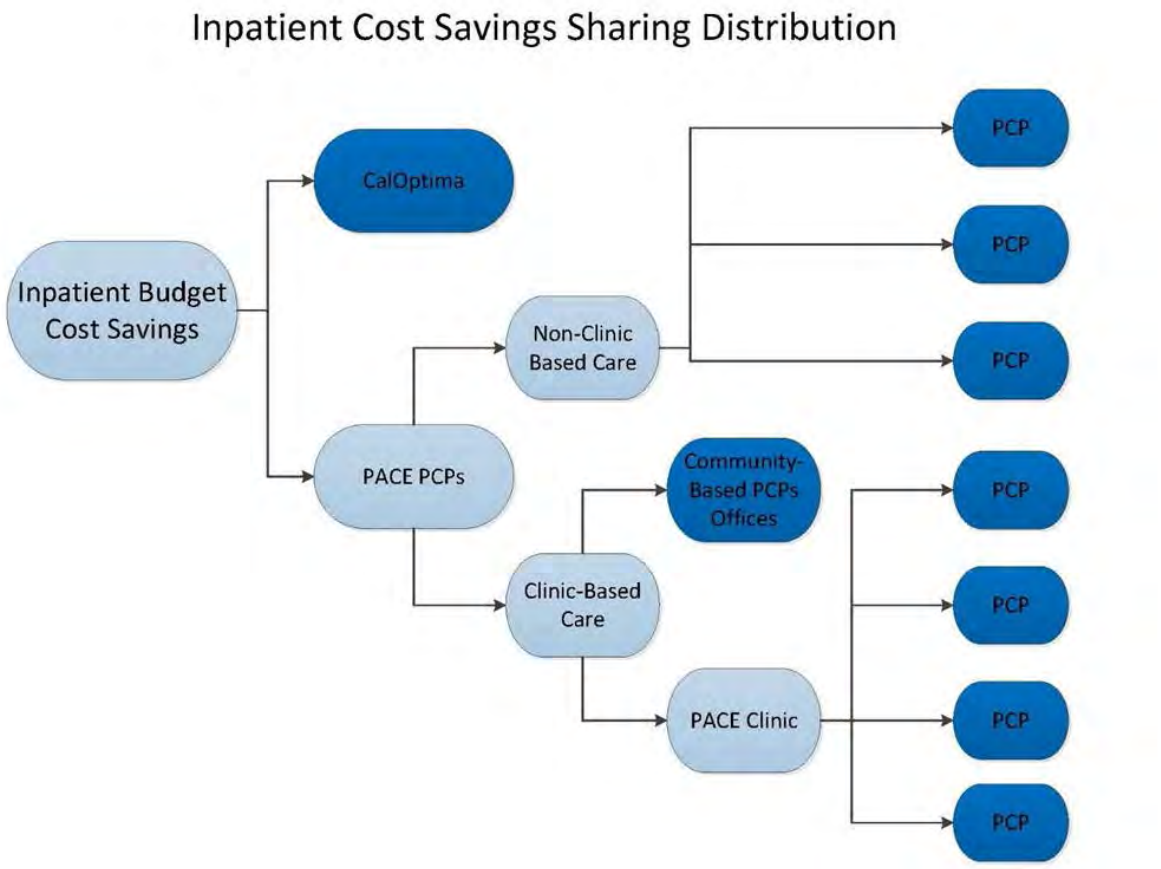
Please note that the implementation of the Incentive Program is subject to regulatory approvals.

In order to be eligible to receive the incentive payments, PCPs must be contracted and in good standing at the time of the payout. Any payouts to otherwise eligible PCPs who are contracted for less than the entire fiscal year will be pro-rated accordingly.

Proposed FY 2020–2021 UM Measure (Inpatient Cost Savings Sharing)

- The UM inpatient cost savings will be apportioned between CalOptima and the PACE PCPs (reference Attachment 4: PACE PCP UM Incentive Grid).
    - CalOptima and the PACE PCPs
        - The first 5% in inpatient cost savings will be apportioned to CalOptima as this target should be met with usual and customary care.
        - PCPs will be able to earn from 25% up to a maximum of 40% of the cumulative inpatient cost savings beyond below the first 5% as outlined in Attachment C, the PACE UM Incentive grid.
        - For comparison, the OneCare and OneCare Connect physician performance shares 50% and the Medi-Cal physician performance shares 60%.
    - Clinic-based care and non-clinic-based care.
        - Those incentives earned by the PACE PCPs will be apportioned to those PCPs providing clinic-based care and those providing non-clinic-based care.
    - Clinic-based care
        - Includes all the primary care taking place in an outpatient setting such as the clinic at the PACE Center, the office of PACE community-based PCP or in the home of a participant who has selected PACE at Home.
        - The UM inpatient cost savings apportioned to those PCPs providing clinic-based care will be further apportioned to the PACE Center clinic PCPs and the community-based PACE PCPs based on the number of assigned participant member months.
        - The UM cost savings incentive apportioned to the PACE PCPs at the PACE Center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
        - Staff recognizes the importance this care has in reducing inappropriate admissions. For example, the better a participant's medical condition, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) is managed, the less likely a participant will need to go to the ER or be admitted to the hospital.
    - Non-clinic-based care
        - Includes all the care occurring outside of the outpatient settings listed above. This includes evaluations and care delivered in the inpatient setting, nursing

facilities and emergency rooms.
  - Any earned UM incentives allocated to the non-clinic-based care will be apportioned based upon the volume of services provided for the above non-clinic-based services as determined by the number of paid claims for these services.
  - The percentage of the UM inpatient cost savings apportioned to the PACE PCPs who are providing non-clinic based care will increase as the savings increases to recognize the additional work being done by these providers who will be performing real-time evaluations in the evenings, on weekends and on holidays to help insure that participants get the care they need in a timely manner.
- The targets for the UM inpatient cost sharing incentive is based on the PACE inpatient budget (determined by the current trend). Appropriate performance targets are based on California PACE Association (CalPACE) and National PACE Association (NPA) benchmarks.
- The UM elements, metrics, goals, and apportioned amounts will be reviewed, updated and approved annually by the Board.



Back to Agenda

Proposed FY 2020–2021 Quality Improvement Measures

- Measures will include:
  - Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care
  - Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction
  - Comprehensive Diabetes Care
    - Annual Diabetic Eye Exams
    - Nephropathy Monitoring
    - Blood Pressure Control
  - Potential Harmful Drug/Disease Interactions in the Elderly: Dementia plus a Tricyclic Antidepressant or Anticholinergic Agent
  - Functional Status Assessment Completion
- The potential QI components of the PACE PCP Incentive Program will be allocated up to $12.50 PMPM and is detailed in Attachment 5: PACE PCP QI Incentive Grid.
- The QI components of the PACE PCP Incentive Program will be apportioned between the PACE PCPs.
  - The QI components of the PACE PCP Incentive Program will be apportioned to the PACE clinic PCPs and the community-based PACE PCPs based on the number of assigned participant member months.
  - The QI components of the PACE PCP Incentive Program apportioned to the PACE PCPs at the PACE Center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The QI measures, metrics and goals will be reviewed and updated annually.

As proposed, all the current PACE PCP contracts reflect these changes in the PACE PCP Incentive Program. Additionally, this program shall be included in all future PACE PCP contracts.

Fiscal Impact

The recommended action to renew the CalOptima PACE PCP Incentive Program for FY 2020-21 is a budgeted item under the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020. The fiscal impact for the QI incentive will not exceed $12.50 PMPM. Staff will make UM incentive distributions to participating providers only if actual inpatient expenses are lower than budgeted amounts.

Rationale for Recommendation

Staff recommends the renewal of the PACE PCP Incentive Program for FY 2020–2021. Streamline the process of administering PACE PCP Incentive Program payments and minimize the need for individual amendments when any changes are made to PACE PCP Incentive Program.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 7, 2017, Specific to the CalOptima PACE program: Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services.
2. Board Action dated June 7, 2018: Consider Authorizing Revision and Expansion of the Program of All-Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts.
3. Board Action dated August 1, 2019: Consider Authorizing Revision and Expansion of the Program of All-Inclusive Care for the Elderly Primary Care Provider Incentive Program and Related Changes to PCP Contracts
4. 2019–2020 PACE PCP Utilization Management Incentive Grid
5. 2019–2020 PACE PCP Quality Improvement Incentive Grid
6. Contracted Entities Covered by this Recommended Action
7. PACE PCP Incentive Program Presentation

/s/ Richard Sanchez — **Authorized Signature**

08/26/2020 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Fiscal Impact
It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation
As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Chambers — *10/28/11*
Authorized Signature — **Date**

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

39. Consider Authorizing Revision and Expansion of the Program of All Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

Specific to the CalOptima PACE Program, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
2. Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
3. Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to help participants continue to live safely at home in the community for as long as possible and to maintain or improve their functional status. CalOptima's program is the first PACE program offered to Orange County residents

At its September 7, 2017 meeting, the Board authorized the CEO to amend the physician services contract with UCI to include the UCI PACE PCP Incentive Program, as well as contracts with non-UCI PCPs as necessary to provide appropriate primary care coverage for the ongoing operation of PACE. At that meeting, the Board also authorized staff to submit the PACE community-based physician waiver which allows members to continue to see their current PCPs while also participating in the PACE program. This waiver was approved by CMS in March 2018.

PCPs have traditionally provided both clinic and non-clinic based care. Clinic-based services are those services rendered in an outpatient clinic, such as the PACE center clinic. Non-clinic based PCP services are those provided outside of an outpatient clinic such as in an emergency room (ER), nursing facility, hospital, or the participant's home. Although it is less common to find community PCPs who provide both clinic and non-clinic based care, it is common within PACE organizations.

The UCI PACE PCP Incentive Program currently includes both Quality Improvement (QI) and Utilization Management (UM) elements. The program has led to significant improvements in all three of the QI elements including overall PACE satisfaction, satisfaction with medical care and reduced coding errors. In 2017, CalOptima PACE program participant satisfaction with medical care and overall satisfaction improved from the previous year and were higher than both the CalPACE and

National PACE averages. The current incentive program allocates $3 per member per month (PMPM) to the three QI incentive elements. As a comparison, management's recommended budget for CalOptima's Community Care Network (CCN) allocates $20 PMPM in FY2018-19.

Unlike the QI incentive elements, the UM inpatient cost savings sharing element has not reached the goal set, with inpatient utilization actually increases year over year. Some of this increase is attributed to the severe flu season this winter. However, even without that event, CalOptima's targeted goals would not have been met. After careful analysis, staff has identified a number of opportunities related to the current program. First, only the UCI PACE PCPs are currently able to participate in the incentive program. Second, the UCI PACE PCPs are only involved in clinic-based care. They are not involved in non-clinic based care such as ER, inpatient (IP) and skilled nursing facility(SNF) care. Third, due to the frailty and age of many of CalOptima's pace participants, they are often admitted unnecessarily as the ER physicians and hospitalists are not familiar with the participants or the resources available in the PACE program.

To better incentivize PCPs serving CalOptima PACE members to address these issues, non-UCI PACE PCPs were recently added as an option for CalOptima PACE members, and the role of the PACE PCP has been expanded to include non-clinic based care (including IP, SNF, ER, and Home Visits) in line with a number of other PACE programs. It is anticipated that these PCPs will provide enhanced, real-time evaluations in the evenings, weekends and on holidays which will include home visits, nursing home evaluations and emergency room evaluations.

Discussion

CalOptima has a long history of incentivizing community partners who go above and beyond in the provision of care to our members. Staff is proposing to revise the UCI PACE PCP Incentive Program (now the PACE PCP Incentive Program) as the PACE PCPs are essential in appropriately assessing a participant's condition as well as avoiding unnecessary ER visits and inpatient admissions. Staff believes that the updated PACE PCP Incentive Program will support quality care, reduce inpatient utilization and promote appropriate use of healthcare resources. The program will continue to have both UM and QI elements. Please note that the implementation of the incentive plan is subject to regulatory approvals.

Staff would like to extend the program to include all current and future PACE PCPs including community-based physicians. PACE will need additional PCPs to provide both clinic-based and non-clinic based care as the program grows and expands into south county. Staff also proposes to increase the number of QI elements and the funds allocated to these elements to bring them more in line with CalOptima's other lines of business. Staff also proposes to revise the distribution of the UM inpatient cost savings sharing element to support the inpatient avoidance strategies. PCPs must be specifically contracted to participate in the PACE PCP Incentive Program. In order to be eligible to receive the incentive payments, PCPs must be contracted and in good standing at the time of the payout. Any payouts to otherwise eligible PCPs who are contracted for less than the entire fiscal year will be pro-rated accordingly.

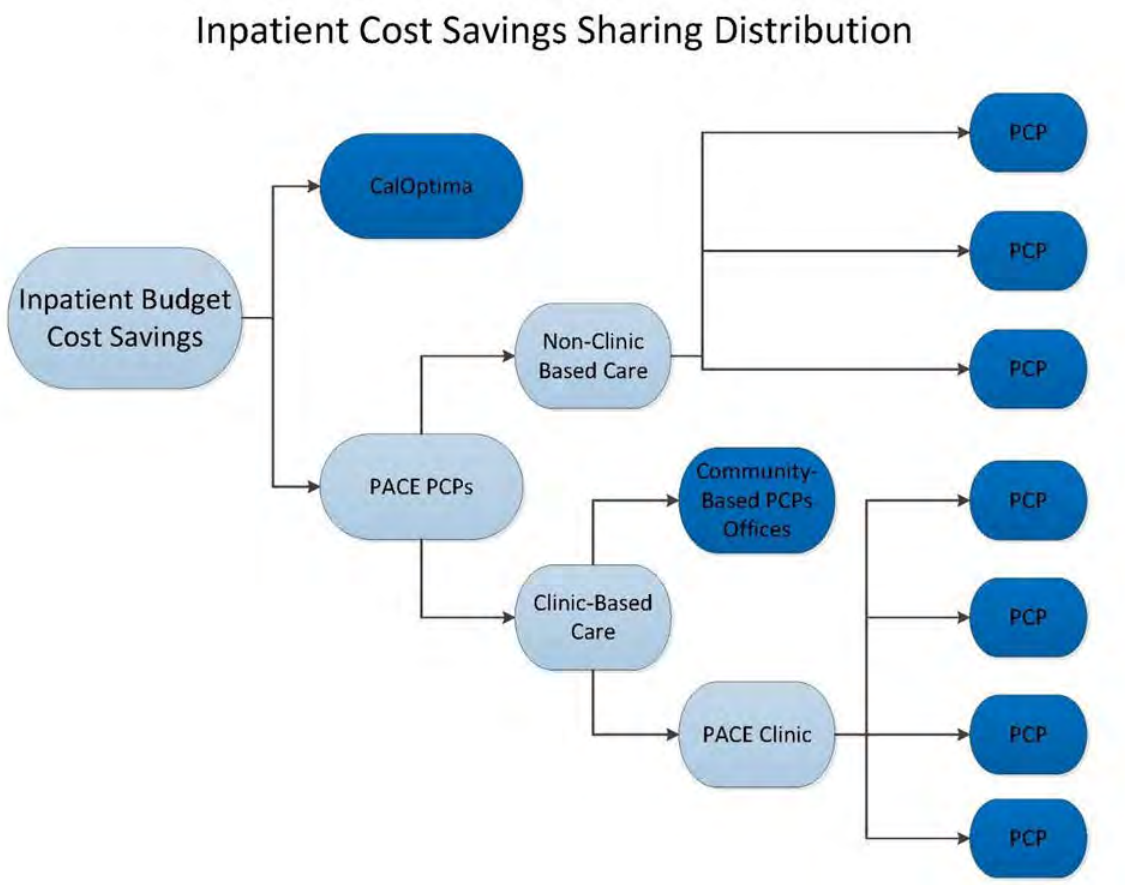
UM Element (Inpatient Cost Savings Sharing)

- The UM inpatient cost savings will be apportioned between CalOptima and the PACE PCPs (reference Attachment A: PACE UM Incentive grid).
    - CalOptima and the PACE PCPs
        - The first 5% in inpatient cost savings will be apportioned to CalOptima as this target should be met with usual and customary care.
        - PCPs will be able to earn up to 40% of the cumulative inpatient cost savings below the first 5% up to the percentages outlined in Attachment A, the PACE UM Incentive grid.
        - For comparison, the One Care and One Care Connect physician performance shares 50% and the Medi-Cal physician performance shares 60%.
    - Clinic-based care and non-clinic based care.
        - Those incentives earned by the PCPs will be apportioned to those PCPs providing clinic-based and those providing non-clinic based care.
        - Clinic-based care
            - Includes all the primary care taking place in an outpatient clinic such as the clinic at the PACE center or in the office of PACE community-based PCP.
            - Staff recognizes the importance of this care has in reducing inappropriate admissions. For example, the better a participant's medical condition, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) is managed, the less likely a participant will need to go to the ER or be admitted to the hospital.
        - Non-clinic based care
            - Includes all of the care occurring outside of an outpatient clinic. This includes evaluations and care delivered in IP, SNF, and ER locations. It also includes evaluations and care which occurs in the participant's home.
            - Any funds allocated to the non-clinic based care will be apportioned based upon the volume of services provided for the above non-clinic based services.
            - The percentage of the UM inpatient cost savings apportioned to the PACE PCPs who are providing non-clinic based care will increase as the savings increases to recognize the additional work being done by these providers who will be performing real-time evaluations in the evenings, on weekends and on holidays to help insure that participants get the care they need in a timely manner.
    - PACE center clinic and community-based physician offices.
        - The UM inpatient cost savings apportioned to those PCPs providing clinic-based care will be further apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
    - PACE center clinic PCPs .

  - The UM cost savings incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The targets for the UM inpatient cost sharing incentive is based on the PACE inpatient budget (determined by the current trend). Appropriate performance targets are based on CalPACE and NPA benchmarks.
- The UM elements, metrics, goals, and apportioned amounts will be reviewed and updated and approved annually by the Board.
- In the future, staff will consider developing a draft policy that would incorporate all of the PACE PCP Incentive Programs activities. Prior to implementation, the draft policy would be brought to the Board for approval.

<u>Incentive Program Transition</u>

- The current PACE PCP Incentive Program began on January 1, 2018 and will end on June 30 2018.
- The current PACE PCP Incentive Program performance will be measured and paid according to the timeline in Attachment D: PACE PCP Incentive January to June 2018 Measurement and Payment Timelines.
- The revised PACE PCP Incentive Program will start on July 1, 2018.



Quality Improvement Elements

- The number of QI elements will increase from three to five.
  - Completion of the physician participant assessments within the regulatory required timeline will be added as a QI element and coding errors will be removed.
  - The participant satisfaction QI elements will be enhanced. Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with medical care and overall satisfaction with the PACE program.
  - Two potentially harmful Drug/Disease Interactions in the Elderly (DDE) elements will be added.
- The potential QI incentives will increase from $3 per member per month (PMPM) to $10 PMPM and are detailed in Attachment B: PACE PCP QI Incentive Grid.
- The QI inpatient cost savings will be apportioned between the PACE PCPs (reference Attachment B: PACE QI Incentive grid).
  - PACE center clinic and community-based physician offices.
    - The QI incentive will be apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
  - PACE center clinic PCPs.
    - The QI incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The QI elements, metrics and goals will be reviewed and updated annually.
- The QI element rates and incentive for the community-based PCPs will be calculated based on the number of member months of those participants assigned to them.

As proposed, the contract with UCI would be amended to reflect these changes in the PACE PCP Incentive program and to include the program in all current and future PACE PCP contracts. In addition,, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract will also be included, as necessary

Fiscal Impact

The recommended action to modify the PACE PCP Incentive Program is a budgeted item under the proposed CalOptima Fiscal Year (FY) 2018-19 Operating Budget, with no additional fiscal impact. Specifically, the QI incentive is budgeted at $10.00 PMPM. Based on the projected PACE enrollment, the estimated annual cost for the QI incentive is approximately $37,000 for FY 2018-19. The UM incentive will not incur additional costs beyond the approved budgeted inpatient expense for FY 2018-19. Distributions to participating providers will only occur if actual inpatient expenses are lower than budgeted amounts.

Rationale for Recommendation

Staff recommends revising the PACE PCP incentive program to better align incentives and ensure that PACE participants cost effectively receive necessary care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: Proposed PACE PCP Incentive Program Revisions
2. Board Action dated September 7, 2017, Specific to the CalOptima PACE program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services.
3. PACE PCP Quality Improvement Incentive Grid
4. PACE PCP Utilization Management Incentive Grid
5. PACE PCP Incentive Program January to June 2018 Measurement and Payment Timelines.

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Proposed PACE PCP Incentive Program Revisions

Board of Directors Meeting

June 7, 2018

Miles Masatsugu, M.D.

Medical Director

Overview of the PACE Program

- To be eligible for PACE, a person must be:
  - 55 years or older
  - Residing in the PACE service area
  - Certified to need nursing facility level care
  - Able to live safely in community

- PACE serves the frailest seniors
  - Average age is older than 80 years
  - Multiple chronic medical conditions
  - High level of functional dependencies (need help bathing, walking, toileting, etc.)

PACE UCI PCP Incentive Background

- University of California, Irvine (UCI) had been providing all of the PCP clinic-based care at PACE since the program began in October 2013.
- Staff started working on a contract update with UCI in December 2016.
- At that time, PACE did not have a pay-for-value or an inpatient cost savings sharing program.
- Inpatient care is one of the highest costs for PACE.
- Most of the elements and goals had been established by June, 2017.

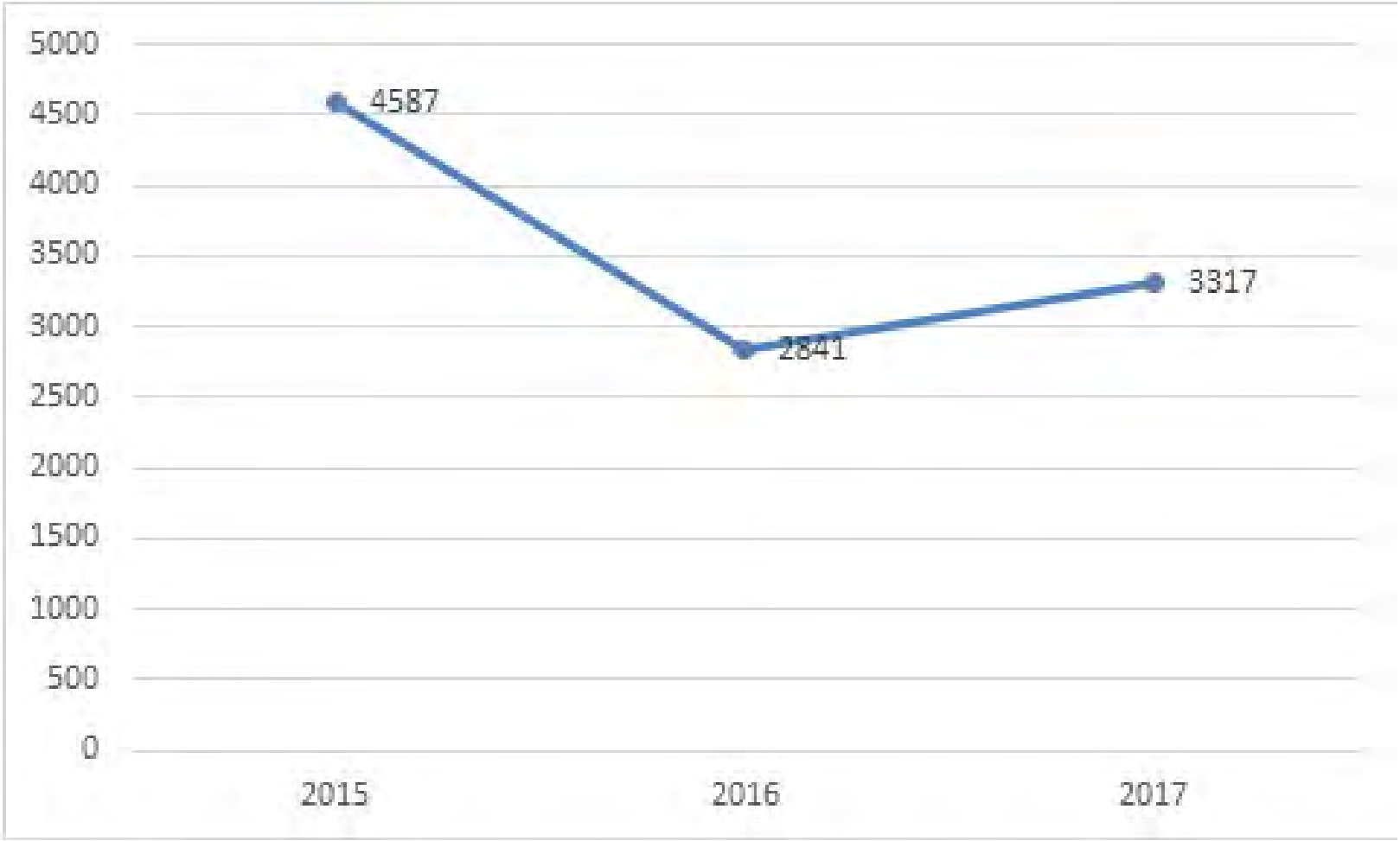
Board Actions

- September 7, 2017: Board authorized four actions via two COBARS
  - UCI PACE PCP incentive program with two components
    - Pay-for-value Quality Improvement (QI) component
      - Overall participant satisfaction
      - Participation satisfaction with medical care
      - Coding error rate
    - A savings sharing Utilization Management (UM) component
      - Based on actual inpatient costs
  - Fellows and residents rotations at PACE
  - Contract with non-UCI PCPs
  - Application for the PACE community-based physician waiver (approved in March, 2018)

Preliminary QI Results: 2017 Annual Participant Satisfaction Survey

Domain	2016 CalOptima PACE	2017 CalOptima PACE	2017 CalPACE Average	2017 National Average
Transportation	98%	**98%**	93%	95.5%
Center Aids	92%	**96%**	93%	91.7%
Home Care	92%	**93%**	87%	87.8%
Medical Care	86%	**92%**	88%	89.5%
Health Care Specialist	85%	**92%**	87%	87.4%
Social Worker	96%	**95%**	94%	95.5%
Meals	71%	**63%**	71%	73.1%
Rehabilitation Therapy and Exercise	98%	**97%**	95%	93.2%
Recreational Therapy	82%	**86%**	84%	82.7%
Other Indicators	92%	**94%**	89%	89.4%
Overall Satisfaction	89%	**90%**	88%	88.4%

Preliminary Utilization Results: Hospital Bed Days (Goal: 2,100 Bed Days/1,000 Participants/Year)



Challenges/Opportunities

- Small number of QI elements
- Funding of the QI component is small compared with CalOptima's other comparable lines of business
- Only UC Irvine PACE PCPs can participate in the incentive program
- UCI PCPs are not directly involved in inpatient and nursing home care
- The frail population and unfamiliarity with PACE leads to unnecessary hospitalizations.

Steps Taken

- September 2017: Board approves 4 actions related to PACE
- October 2017: UCI PACE PCP contract amended
- October 2017: PACE contracts with House Call Medical Associates (HCMA) for PCP services
- November 2017: HCMA assumes most inpatient and Skilled Nursing Facility (SNF) care
- January 2018: UCI PACE PCP incentive begins for remainder of fiscal year (ends 6/30/18)
- May 2018: Presented to CalOptima Board of Directors Quality Assurance Committee

Proposed Modifications to PACE PCP Incentive Program

- Allow all PACE PCPs to participate in the PACE incentive program, including community-based physicians
- Increase the number of QI elements
- Increase QI incentive from $3 PMPM to $10 PMPM.
- Change distribution of UM component (savings sharing) to support inpatient avoidance strategies
  - After-hours telephonic coordination of care
  - After-hours home visit evaluations
  - Admission directly to SNFs for appropriate cases
  - ER evaluations with observation stays

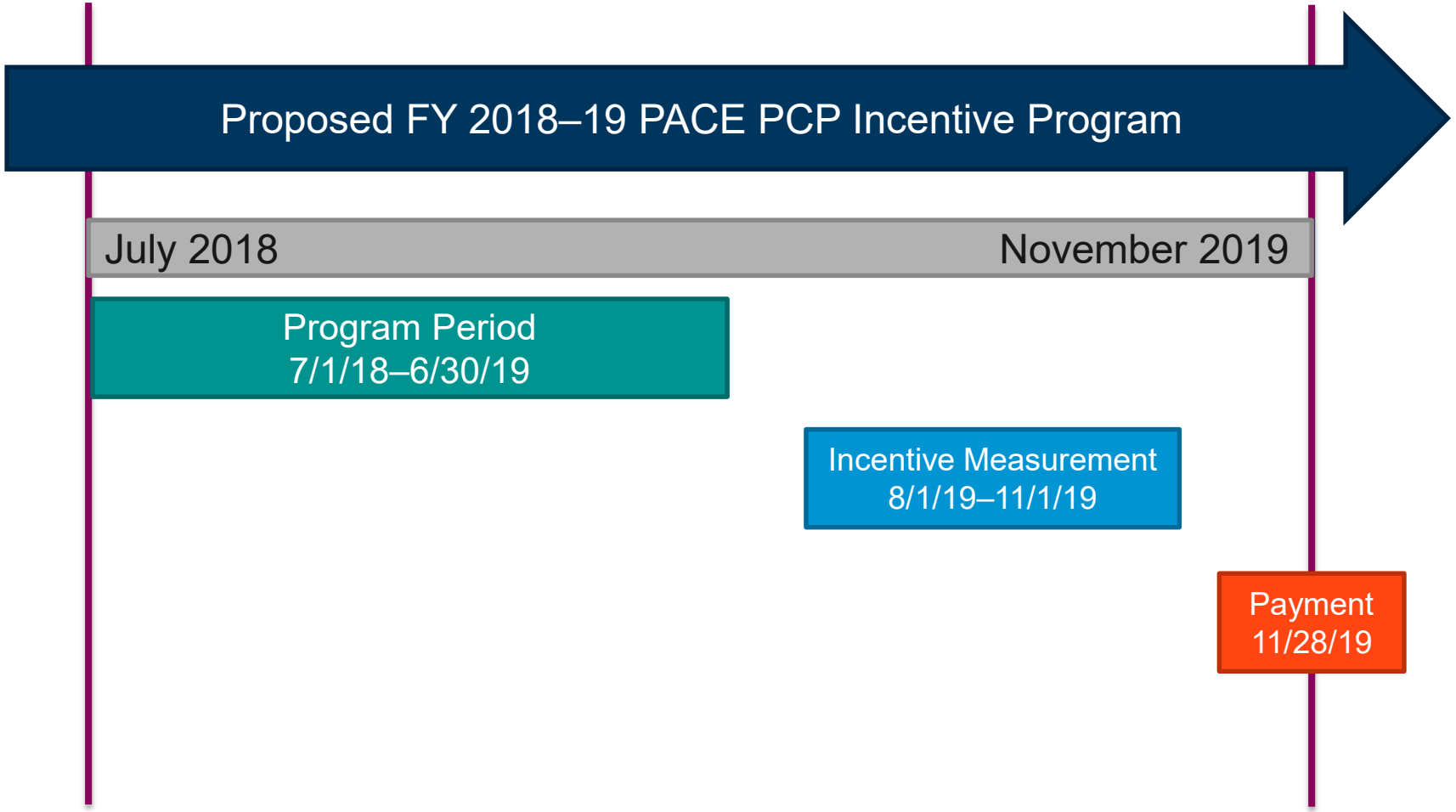
Proposed QI Incentive Elements

Elements	Current	Proposed
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	✓	✓
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	✓	✓
Coding Errors	✓	
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus tricyclic antidepressants or antipsychotics		✓
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia plus tricyclic antidepressant or anticholinergic agents		✓
Functional Status Assessment		✓
Total Potential QI Incentive	**$3 PMPM**	**$10 PMPM**

Proposed UM Incentive (Savings Sharing)

	Budget	Sharing by Tier Level		Cumulative Total Savings		PCP Role (Distribution by Tier)	
	100%	CalOptima	PCP	CalOptima	PCP	Non-clinic based (IP, ER, SNF, Home Visits)	Clinic-based
Tier 1	95%–100%	100%	0%	100%	$0	N/A	N/A
Tier 2	90%–95%	50%	50%	75%	25%	75%	25%
Tier 3	85%–90%	50%	50%	67%	33%	80%	20%
Tier 4	80%–85%	50%	50%	63%	38%	85%	15%
Tier 5 (Incentive Ends)	75%–80%	50%	50%	60%	40%	90%	10%

Proposed Timeline



Recommendation

- Specific to the CalOptima PACE Program, consider authorizing the Chief Executive Officer (CEO), with the assistance of Legal Counsel to:
  - Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
  - Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
  - Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contacts, including those of community-based physicians serving CalOptima PACE members.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Fiscal Impact
It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation
As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Chambers — *10/28/11*
Authorized Signature — **Date**

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda Back to Item

2018-2019 CalOptima PACE PCP Incentive Program Grid

QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY	August	TruChart Analytics and Pharmacy Utliization Report. 2016 HEDIS Quality Compas 90th percentile is <37.50%.	>/=37.50%	$0 PMPM	January
					<37.50%	$2 PMPM	
QI: Functional Status Assessment	At a minimum, all participants need a complete Functional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$10	January

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda Back to Item

2018-2019 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail										Paid
UM; CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PCP care including real-time evaluations in the evenings and weeksends at the participant's homes, ER's and SNF's will be important in ensuring particiapnts gets timely, appropriate care. The structure of this program avoids any risk to the PCP.	FY 2019	Audited FY Performance	PCP receives % of the actual inpatient cost savings calculated from the audited FY financial.	Tier	Performance (% below Budget)	Maximum % Savings from Inpatient Budget	% of UM Savings to Cal Optima by Tier	% of UM Savings to PCPs by Tier	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Clinic-Based Services	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of UM Savigs to Cal Optima	Cumulative % of UM Savings to PACE PCP's UM Incentive	Nov-19
					Budget	100%								
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	**100%**	**0%**	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	**75%**	**25%**	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	**67%**	**33%**	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	**63%**	**38%**	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	**60%**	**40%**	

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center

Back to Agenda

Back to Item

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	Jan 1, 2018 to June 30th, 2018	Oct-18	The CalOptima Coding Department will audit 100% of the charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	Nov-18
					75-89%	$0.5 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	Jan 1, 2018 to June 30th, 2018	Audited FY Performance September 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $20 PMPM or $31,020***	Nov-18
					Incentive ends at BD / K / Y equivalent of 2,000		

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Authorizing Revision and Expansion of the Program of All-Inclusive Care for the Elderly Primary Care Provider Incentive Program and Related Changes to PCP Contracts

Contact

David Ramirez, Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

Specific to the CalOptima PACE Program, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Revise the CalOptima Program of All-Inclusive Care (PACE) Primary Care Physician (PCP) Incentive Program, subject to applicable regulatory approval(s);
2. Ratify the amendment to CalOptima's current PACE PCP contracts to modify the PACE PCP Incentive Program; and
3. Include the PACE PCP Incentive Program in any future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of the PACE program are to help participants continue to live safely at home in the community for as long as possible and to maintain or improve their functional status. CalOptima's program is the first PACE program offered to Orange County residents

At its September 7, 2017 meeting, the Board authorized amendment to the physician services contract with UCI to include the UCI PACE PCP Incentive Program. At that meeting, the Board also authorized staff to submit the PACE community-based physician waiver which allows members to continue to see their current PCPs while also participating in the PACE program (reference Attachment A: Board Action dated September 7, 2017). This waiver was approved by CMS in March 2018.

At its June 7, 2018 meeting, the Board authorized the revision of the UCI PACE PCP Incentive Program, subsequently renamed the PACE PCP Incentive Program, along with its expansion to all the PACE PCP contracts including community-based PACE PCPs (reference Attachment B: Board Action dated June 7, 2018).

PCPs have traditionally provided both clinic and non-clinic-based care. Clinic-based services are those services rendered in an outpatient clinic, such as the PACE center clinic. Non-clinic-based PCP services are those provided outside of an outpatient clinic such as in an emergency room (ER), nursing facility or hospital. Although it is less common to find community PCPs who provide both clinic and non-clinic-based care, it is common within PACE organizations.

Back to Agenda Back to Item

The current PACE PCP Incentive Program includes both Quality Improvement (QI) and Utilization Management (UM) measures. Additionally, the incentive program allows those PACE PCPs involved in non-clinic-based care to participate, including those involved with inpatient care, nursing facility care, home visits and after-hours on-call. This has resulted in an increase in the number of after-hour and weekend in person evaluations at members' homes and an increase in the number of diversions from emergency rooms to nursing facilities for workups, which has led to a decrease in our inpatient utilization. With the QI measures, we have seen a decrease in the number of participants with dementia who are on a tricyclic antidepressant or an anticholinergic agent and a decrease in those participants with a history of falls who are on a tricyclic antidepressant or antipsychotic medication.

The current incentive program allocates up to $10 per member per month (PMPM) to the five QI incentive measures. As a comparison, management's recommended budget for CalOptima's Community Care Network (CCN) allocates $20 PMPM in Fiscal Year (FY) 2018-19.

Discussion

CalOptima has a long history of incentivizing community partners who go above and beyond in the provision of care to our members. Including the PACE PCPs involved in non-clinic-based care has led to more thorough after-hours evaluations which has improved the of quality care, reduced inpatient utilization and has promoted appropriate use of healthcare resources. Staff is proposing to continue the UM element of this incentive program for FY 2019-2020.

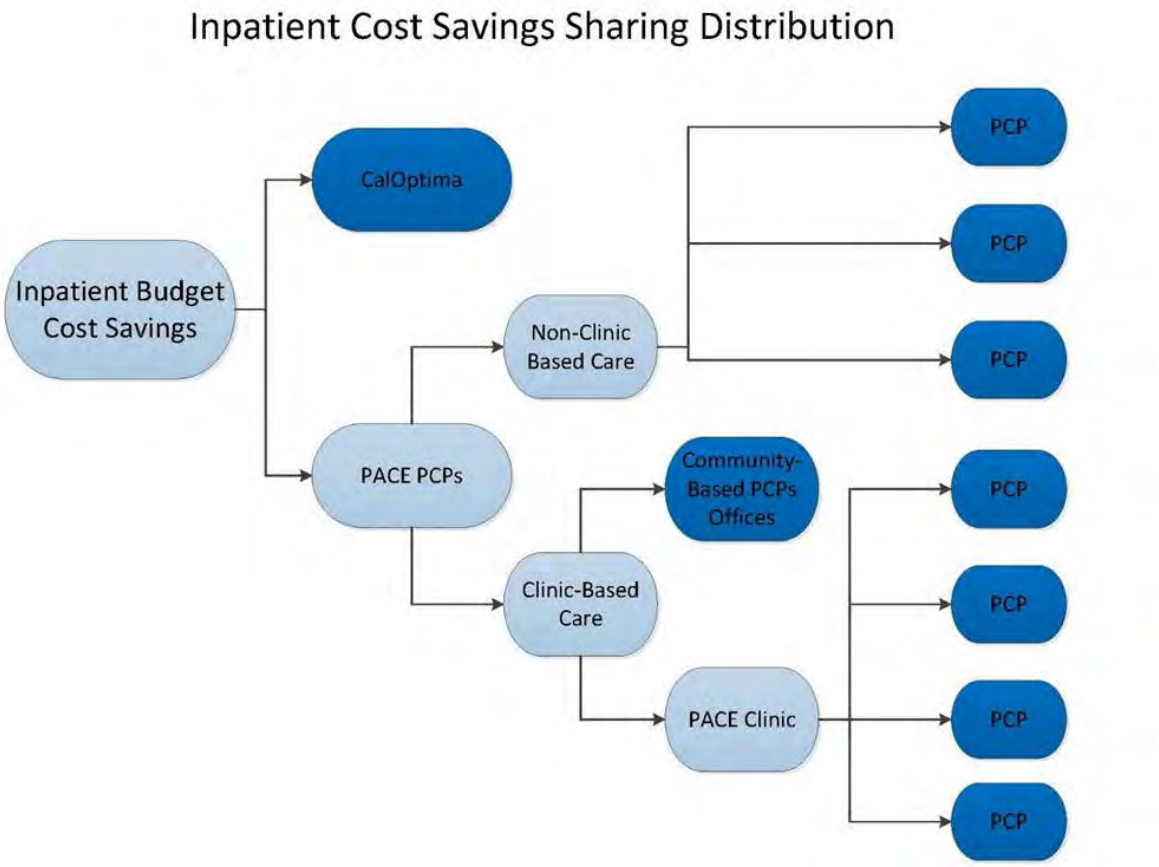
Staff is proposing to slightly revise the QI measures in the PACE PCP Incentive Program by removing one element and adding three new diabetes-based elements. Diabetes continues to be one of the medical conditions that leads to a great deal of morbidity and mortality in the PACE population. By revising the QI measures as proposed, we would increase the potential QI incentive from the $10 PMPM allocated level in 2018-19 to $12.50 PMPM in 2019-20. This would bring it more in line with CalOptima's other lines of business. Staff also proposes to maintain the same distribution methodology. Please note that the implementation of the incentive plan is subject to regulatory approvals.

In order to be eligible to receive the incentive payments, PCPs providing the care must also be contracted and in good standing at the time of the payout. Any payouts to otherwise eligible PCPs who are contracted for less than the entire fiscal year will be pro-rated accordingly.

UM Measure (Inpatient Cost Savings Sharing)

- The UM inpatient cost savings will be apportioned between CalOptima and the PACE PCPs (reference Attachment C: PACE PCP UM Incentive grid).
  - CalOptima and the PACE PCPs
    - The first 5% in inpatient cost savings will be apportioned to CalOptima as this target should be met with usual and customary care.
    - PCPs will be able to earn from 25% up to a maximum of 40% of the cumulative inpatient cost savings below the first 5% as outlined in Attachment C, the PACE UM Incentive grid.
    - For comparison, the One Care and One Care Connect physician performance shares 50% and the Medi-Cal physician performance shares 60%.

- Clinic-based care and non-clinic based care.
  - Those incentives earned by the PACE PCPs will be apportioned to those PCPs providing clinic-based and those providing non-clinic based care.
  - Clinic-based care
- Includes all the primary care taking place in an outpatient setting such as the clinic at the PACE center, the office of PACE community-based PCP or in the home of a participant who has selected PACE at Home.
- The UM inpatient cost savings apportioned to those PCPs providing clinic-based care will be further apportioned to the PACE center clinic PCPs and the community-based PACE PCPs based on the number of assigned participant member months.
- The UM cost savings incentive apportioned to the PACE PCPs at the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- Staff recognizes the importance of this care has in reducing inappropriate admissions. For example, the better a participant's medical condition, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) is managed, the less likely a participant will need to go to the ER or be admitted to the hospital.
  - Non-clinic-based care
- Includes all the care occurring outside of the outpatient settings listed above. This includes evaluations and care delivered in the inpatient setting, nursing facilities and emergency rooms.
- Any earned UM incentives allocated to the non-clinic-based care will be apportioned based upon the volume of services provided for the above non-clinic-based services as determined by the amount of paid claims for these services.
- The percentage of the UM inpatient cost savings apportioned to the PACE PCPs who are providing non-clinic based care will increase as the savings increases to recognize the additional work being done by these providers who will be performing real-time evaluations in the evenings, on weekends and on holidays to help insure that participants get the care they need in a timely manner.
  - The targets for the UM inpatient cost sharing incentive is based on the PACE inpatient budget (determined by the current trend). Appropriate performance targets are based on CalPACE and NPA benchmarks.
- The UM elements, metrics, goals, and apportioned amounts will be reviewed and updated and approved annually by the Board.


Inpatient Cost Savings Sharing Distribution
Inpatient Budget Cost Savings
CalOptima
PACE PCPs
Non-Clinic Based Care
Clinic-Based Care
Community-Based PCPs Offices
PACE Clinic
PCP
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PCP
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Quality Improvement Measures

- The number of QI measures will increase from five to seven
  - Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus Tricyclic Antidepressants or Antipsychotics will be removed.
  - Three Comprehensive Diabetes Care (CDC) elements will be added.
    - Diabetics with a blood pressure <140/90.
    - Diabetics with a completed Annual Eye Exam.
    - Diabetics with Nephropathy monitoring.
  - Participant Satisfaction with Medical Care, Overall Participant Satisfaction, Functional Status Assessment Completion and Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia plus Tricyclic Antidepressants or Antipsychotics will remain.
- The potential QI incentives will increase from $10 PMPM to $12.50 PMPM and is detailed in Attachment D: PACE PCP QI Incentive Grid.
- The QI incentive will be apportioned between the PACE PCPs.
  - The QI incentive will be apportioned to the PACE clinic PCPs and the community-based PACE PCP based on the number of assigned participant member months.
  - The QI incentive apportioned to the PACE PCPs at the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The QI measures, metrics and goals will be reviewed and updated annually.

As proposed, all the current PACE PCP contracts amendments would be ratified to reflect these changes in the PACE PCP Incentive program. Additionally, this program shall be included in all future PACE PCP contracts. Staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract will also be included, as necessary

Fiscal Impact

The recommended action to revise the PACE PCP Incentive Program is a budgeted item under the CalOptima FY 2019-20 Operating Budget approved by the Board on June 6, 2019. Based on the projected PACE enrollment and the budgeted QI incentive at $12.50 PMPM, the estimated annual cost is approximately $57,500 for FY 2019-20.

The UM incentive will not result in additional costs beyond the amounts included in the CalOptima FY 2019-20 Operating Budget. CalOptima staff will make incentive distributions to participating providers only if actual inpatient expenses are lower than budgeted amounts.

Rationale for Recommendation

Staff recommends slight revisions in the PACE PCP incentive program for FY 2019-2020 to better align incentives and ensure that PACE participants cost effectively receive necessary care.

Concurrence
Gary Crockett, Chief Counsel
Attachments

1. Contracted Entities Covered by this Recommended Action
2. Board Action dated September 7, 2017, Specific to the CalOptima PACE program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services.
3. Board Action dated June 7, 2018, Consider Authorizing Revision and Expansion of the Program of All-Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts.
4. 2019-2020 PACE PCP Utilization Management Incentive Grid
5. 2019-2020 PACE PCP Quality Improvement Incentive Grid

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Fiscal Impact
It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation
As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Chambers — *10/28/11*
Authorized Signature — **Date**

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

39. Consider Authorizing Revision and Expansion of the Program of All Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

Specific to the CalOptima PACE Program, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
2. Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
3. Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to help participants continue to live safely at home in the community for as long as possible and to maintain or improve their functional status. CalOptima's program is the first PACE program offered to Orange County residents

At its September 7, 2017 meeting, the Board authorized the CEO to amend the physician services contract with UCI to include the UCI PACE PCP Incentive Program, as well as contracts with non-UCI PCPs as necessary to provide appropriate primary care coverage for the ongoing operation of PACE. At that meeting, the Board also authorized staff to submit the PACE community-based physician waiver which allows members to continue to see their current PCPs while also participating in the PACE program. This waiver was approved by CMS in March 2018.

PCPs have traditionally provided both clinic and non-clinic based care. Clinic-based services are those services rendered in an outpatient clinic, such as the PACE center clinic. Non-clinic based PCP services are those provided outside of an outpatient clinic such as in an emergency room (ER), nursing facility, hospital, or the participant's home. Although it is less common to find community PCPs who provide both clinic and non-clinic based care, it is common within PACE organizations.

The UCI PACE PCP Incentive Program currently includes both Quality Improvement (QI) and Utilization Management (UM) elements. The program has led to significant improvements in all three of the QI elements including overall PACE satisfaction, satisfaction with medical care and reduced coding errors. In 2017, CalOptima PACE program participant satisfaction with medical care and overall satisfaction improved from the previous year and were higher than both the CalPACE and

National PACE averages. The current incentive program allocates $3 per member per month (PMPM) to the three QI incentive elements. As a comparison, management's recommended budget for CalOptima's Community Care Network (CCN) allocates $20 PMPM in FY2018-19.

Unlike the QI incentive elements, the UM inpatient cost savings sharing element has not reached the goal set, with inpatient utilization actually increases year over year. Some of this increase is attributed to the severe flu season this winter. However, even without that event, CalOptima's targeted goals would not have been met. After careful analysis, staff has identified a number of opportunities related to the current program. First, only the UCI PACE PCPs are currently able to participate in the incentive program. Second, the UCI PACE PCPs are only involved in clinic-based care. They are not involved in non-clinic based care such as ER, inpatient (IP) and skilled nursing facility(SNF) care. Third, due to the frailty and age of many of CalOptima's pace participants, they are often admitted unnecessarily as the ER physicians and hospitalists are not familiar with the participants or the resources available in the PACE program.

To better incentivize PCPs serving CalOptima PACE members to address these issues, non-UCI PACE PCPs were recently added as an option for CalOptima PACE members, and the role of the PACE PCP has been expanded to include non-clinic based care (including IP, SNF, ER, and Home Visits) in line with a number of other PACE programs. It is anticipated that these PCPs will provide enhanced, real-time evaluations in the evenings, weekends and on holidays which will include home visits, nursing home evaluations and emergency room evaluations.

Discussion

CalOptima has a long history of incentivizing community partners who go above and beyond in the provision of care to our members. Staff is proposing to revise the UCI PACE PCP Incentive Program (now the PACE PCP Incentive Program) as the PACE PCPs are essential in appropriately assessing a participant's condition as well as avoiding unnecessary ER visits and inpatient admissions. Staff believes that the updated PACE PCP Incentive Program will support quality care, reduce inpatient utilization and promote appropriate use of healthcare resources. The program will continue to have both UM and QI elements. Please note that the implementation of the incentive plan is subject to regulatory approvals.

Staff would like to extend the program to include all current and future PACE PCPs including community-based physicians. PACE will need additional PCPs to provide both clinic-based and non-clinic based care as the program grows and expands into south county. Staff also proposes to increase the number of QI elements and the funds allocated to these elements to bring them more in line with CalOptima's other lines of business. Staff also proposes to revise the distribution of the UM inpatient cost savings sharing element to support the inpatient avoidance strategies. PCPs must be specifically contracted to participate in the PACE PCP Incentive Program. In order to be eligible to receive the incentive payments, PCPs must be contracted and in good standing at the time of the payout. Any payouts to otherwise eligible PCPs who are contracted for less than the entire fiscal year will be pro-rated accordingly.

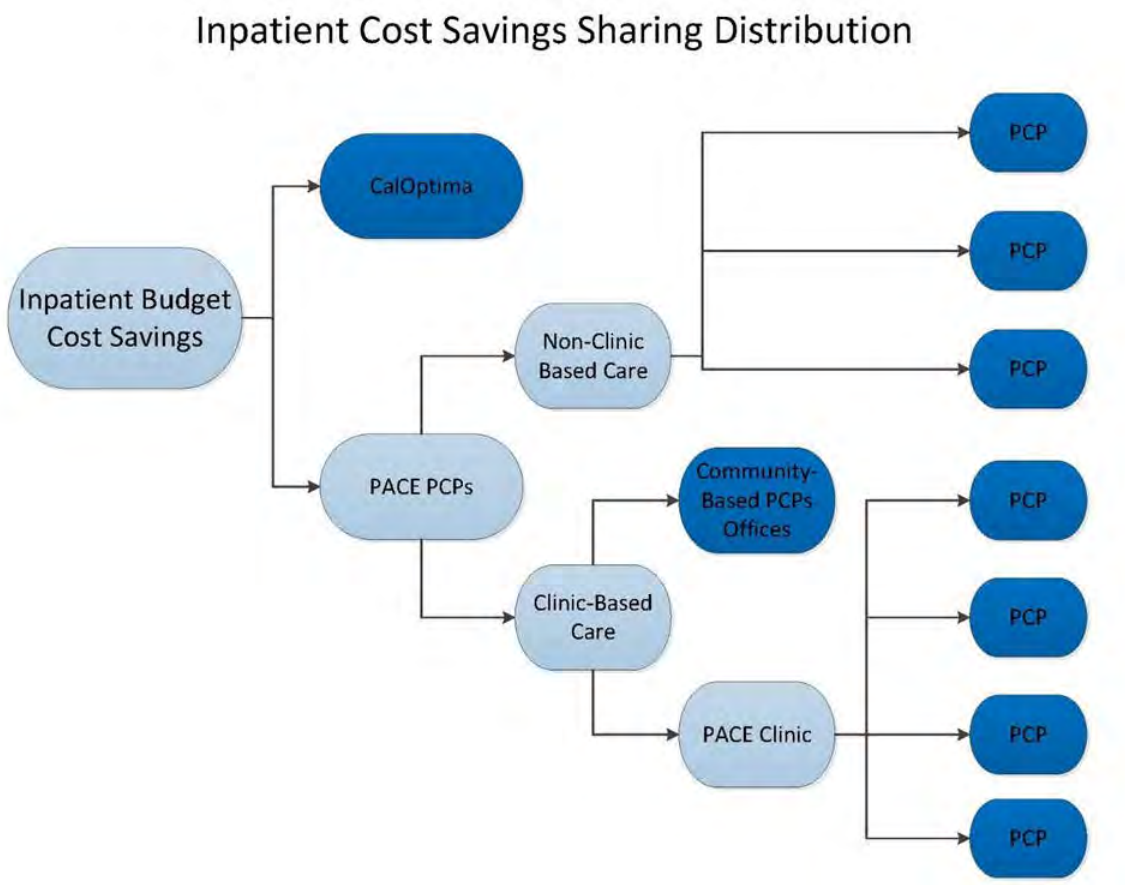
UM Element (Inpatient Cost Savings Sharing)

- The UM inpatient cost savings will be apportioned between CalOptima and the PACE PCPs (reference Attachment A: PACE UM Incentive grid).
    - CalOptima and the PACE PCPs
        - The first 5% in inpatient cost savings will be apportioned to CalOptima as this target should be met with usual and customary care.
        - PCPs will be able to earn up to 40% of the cumulative inpatient cost savings below the first 5% up to the percentages outlined in Attachment A, the PACE UM Incentive grid.
        - For comparison, the One Care and One Care Connect physician performance shares 50% and the Medi-Cal physician performance shares 60%.
    - Clinic-based care and non-clinic based care.
        - Those incentives earned by the PCPs will be apportioned to those PCPs providing clinic-based and those providing non-clinic based care.
        - Clinic-based care
            - Includes all the primary care taking place in an outpatient clinic such as the clinic at the PACE center or in the office of PACE community-based PCP.
            - Staff recognizes the importance of this care has in reducing inappropriate admissions. For example, the better a participant's medical condition, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) is managed, the less likely a participant will need to go to the ER or be admitted to the hospital.
        - Non-clinic based care
            - Includes all of the care occurring outside of an outpatient clinic. This includes evaluations and care delivered in IP, SNF, and ER locations. It also includes evaluations and care which occurs in the participant's home.
            - Any funds allocated to the non-clinic based care will be apportioned based upon the volume of services provided for the above non-clinic based services.
            - The percentage of the UM inpatient cost savings apportioned to the PACE PCPs who are providing non-clinic based care will increase as the savings increases to recognize the additional work being done by these providers who will be performing real-time evaluations in the evenings, on weekends and on holidays to help insure that participants get the care they need in a timely manner.
    - PACE center clinic and community-based physician offices.
        - The UM inpatient cost savings apportioned to those PCPs providing clinic-based care will be further apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
    - PACE center clinic PCPs .

  - The UM cost savings incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The targets for the UM inpatient cost sharing incentive is based on the PACE inpatient budget (determined by the current trend). Appropriate performance targets are based on CalPACE and NPA benchmarks.
- The UM elements, metrics, goals, and apportioned amounts will be reviewed and updated and approved annually by the Board.
- In the future, staff will consider developing a draft policy that would incorporate all of the PACE PCP Incentive Programs activities. Prior to implementation, the draft policy would be brought to the Board for approval.

<u>Incentive Program Transition</u>

- The current PACE PCP Incentive Program began on January 1, 2018 and will end on June 30 2018.
- The current PACE PCP Incentive Program performance will be measured and paid according to the timeline in Attachment D: PACE PCP Incentive January to June 2018 Measurement and Payment Timelines.
- The revised PACE PCP Incentive Program will start on July 1, 2018.



Quality Improvement Elements

- The number of QI elements will increase from three to five.
  - Completion of the physician participant assessments within the regulatory required timeline will be added as a QI element and coding errors will be removed.
  - The participant satisfaction QI elements will be enhanced. Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with medical care and overall satisfaction with the PACE program.
  - Two potentially harmful Drug/Disease Interactions in the Elderly (DDE) elements will be added.
- The potential QI incentives will increase from $3 per member per month (PMPM) to $10 PMPM and are detailed in Attachment B: PACE PCP QI Incentive Grid.
- The QI inpatient cost savings will be apportioned between the PACE PCPs (reference Attachment B: PACE QI Incentive grid).
  - PACE center clinic and community-based physician offices.
    - The QI incentive will be apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
  - PACE center clinic PCPs.
    - The QI incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The QI elements, metrics and goals will be reviewed and updated annually.
- The QI element rates and incentive for the community-based PCPs will be calculated based on the number of member months of those participants assigned to them.

As proposed, the contract with UCI would be amended to reflect these changes in the PACE PCP Incentive program and to include the program in all current and future PACE PCP contracts. In addition,, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract will also be included, as necessary

Fiscal Impact

The recommended action to modify the PACE PCP Incentive Program is a budgeted item under the proposed CalOptima Fiscal Year (FY) 2018-19 Operating Budget, with no additional fiscal impact. Specifically, the QI incentive is budgeted at $10.00 PMPM. Based on the projected PACE enrollment, the estimated annual cost for the QI incentive is approximately $37,000 for FY 2018-19. The UM incentive will not incur additional costs beyond the approved budgeted inpatient expense for FY 2018-19. Distributions to participating providers will only occur if actual inpatient expenses are lower than budgeted amounts.

Rationale for Recommendation

Staff recommends revising the PACE PCP incentive program to better align incentives and ensure that PACE participants cost effectively receive necessary care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: Proposed PACE PCP Incentive Program Revisions
2. Board Action dated September 7, 2017, Specific to the CalOptima PACE program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services.
3. PACE PCP Quality Improvement Incentive Grid
4. PACE PCP Utilization Management Incentive Grid
5. PACE PCP Incentive Program January to June 2018 Measurement and Payment Timelines.

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Proposed PACE PCP Incentive Program Revisions

Board of Directors Meeting

June 7, 2018

Miles Masatsugu, M.D.

Medical Director

Overview of the PACE Program

- To be eligible for PACE, a person must be:
  - 55 years or older
  - Residing in the PACE service area
  - Certified to need nursing facility level care
  - Able to live safely in community

- PACE serves the frailest seniors
  - Average age is older than 80 years
  - Multiple chronic medical conditions
  - High level of functional dependencies (need help bathing, walking, toileting, etc.)

PACE UCI PCP Incentive Background

- University of California, Irvine (UCI) had been providing all of the PCP clinic-based care at PACE since the program began in October 2013.
- Staff started working on a contract update with UCI in December 2016.
- At that time, PACE did not have a pay-for-value or an inpatient cost savings sharing program.
- Inpatient care is one of the highest costs for PACE.
- Most of the elements and goals had been established by June, 2017.

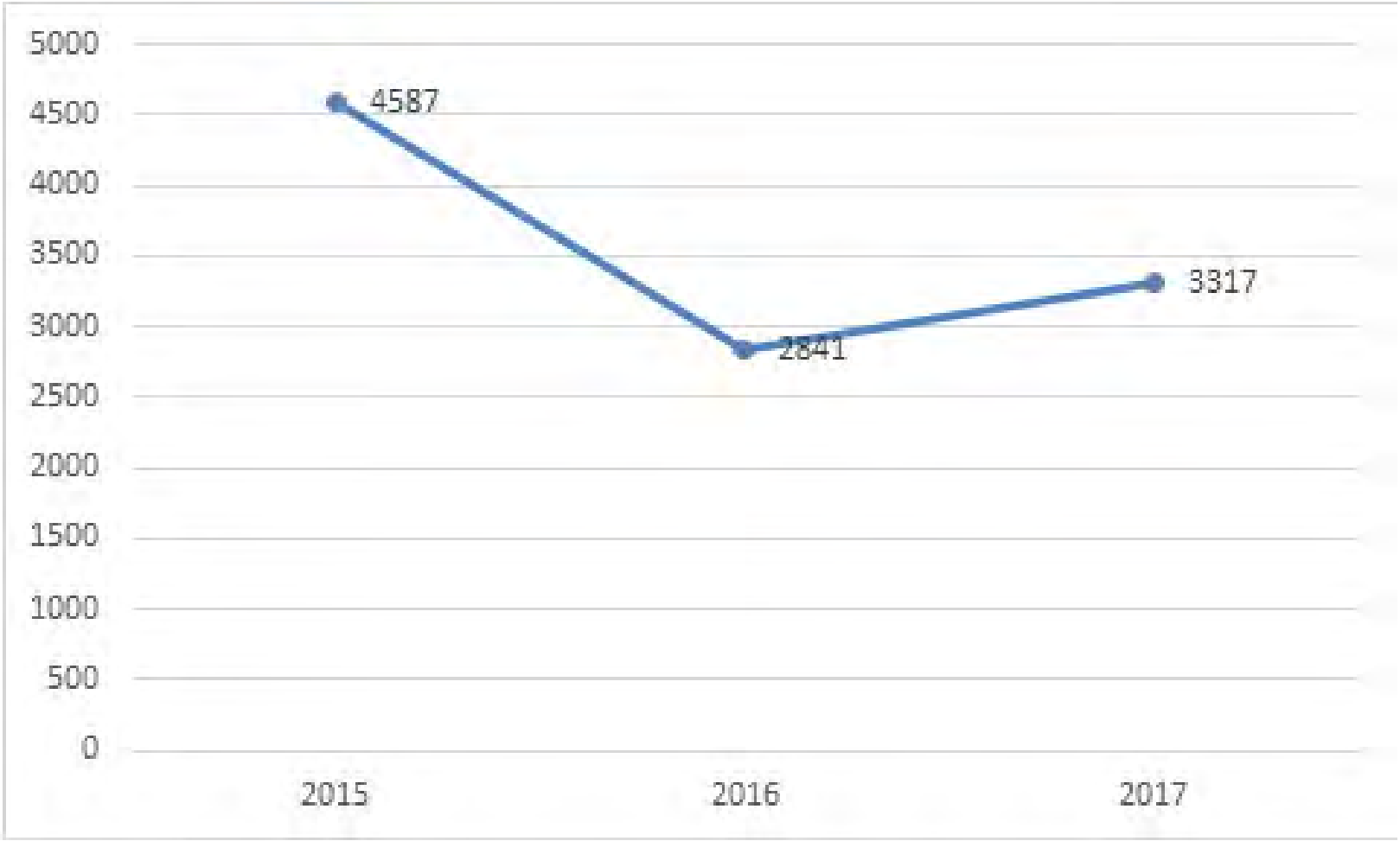
Board Actions

- September 7, 2017: Board authorized four actions via two COBARS
  - UCI PACE PCP incentive program with two components
    - Pay-for-value Quality Improvement (QI) component
      - Overall participant satisfaction
      - Participation satisfaction with medical care
      - Coding error rate
    - A savings sharing Utilization Management (UM) component
      - Based on actual inpatient costs
  - Fellows and residents rotations at PACE
  - Contract with non-UCI PCPs
  - Application for the PACE community-based physician waiver (approved in March, 2018)

Preliminary QI Results: 2017 Annual Participant Satisfaction Survey

Domain	2016 CalOptima PACE	2017 CalOptima PACE	2017 CalPACE Average	2017 National Average
Transportation	98%	**98%**	93%	95.5%
Center Aids	92%	**96%**	93%	91.7%
Home Care	92%	**93%**	87%	87.8%
Medical Care	86%	**92%**	88%	89.5%
Health Care Specialist	85%	**92%**	87%	87.4%
Social Worker	96%	**95%**	94%	95.5%
Meals	71%	**63%**	71%	73.1%
Rehabilitation Therapy and Exercise	98%	**97%**	95%	93.2%
Recreational Therapy	82%	**86%**	84%	82.7%
Other Indicators	92%	**94%**	89%	89.4%
Overall Satisfaction	89%	**90%**	88%	88.4%

Preliminary Utilization Results: Hospital Bed Days (Goal: 2,100 Bed Days/1,000 Participants/Year)



Challenges/Opportunities

- Small number of QI elements
- Funding of the QI component is small compared with CalOptima's other comparable lines of business
- Only UC Irvine PACE PCPs can participate in the incentive program
- UCI PCPs are not directly involved in inpatient and nursing home care
- The frail population and unfamiliarity with PACE leads to unnecessary hospitalizations.

Steps Taken

- September 2017: Board approves 4 actions related to PACE
- October 2017: UCI PACE PCP contract amended
- October 2017: PACE contracts with House Call Medical Associates (HCMA) for PCP services
- November 2017: HCMA assumes most inpatient and Skilled Nursing Facility (SNF) care
- January 2018: UCI PACE PCP incentive begins for remainder of fiscal year (ends 6/30/18)
- May 2018: Presented to CalOptima Board of Directors Quality Assurance Committee

Proposed Modifications to PACE PCP Incentive Program

- Allow all PACE PCPs to participate in the PACE incentive program, including community-based physicians
- Increase the number of QI elements
- Increase QI incentive from $3 PMPM to $10 PMPM.
- Change distribution of UM component (savings sharing) to support inpatient avoidance strategies
  - After-hours telephonic coordination of care
  - After-hours home visit evaluations
  - Admission directly to SNFs for appropriate cases
  - ER evaluations with observation stays

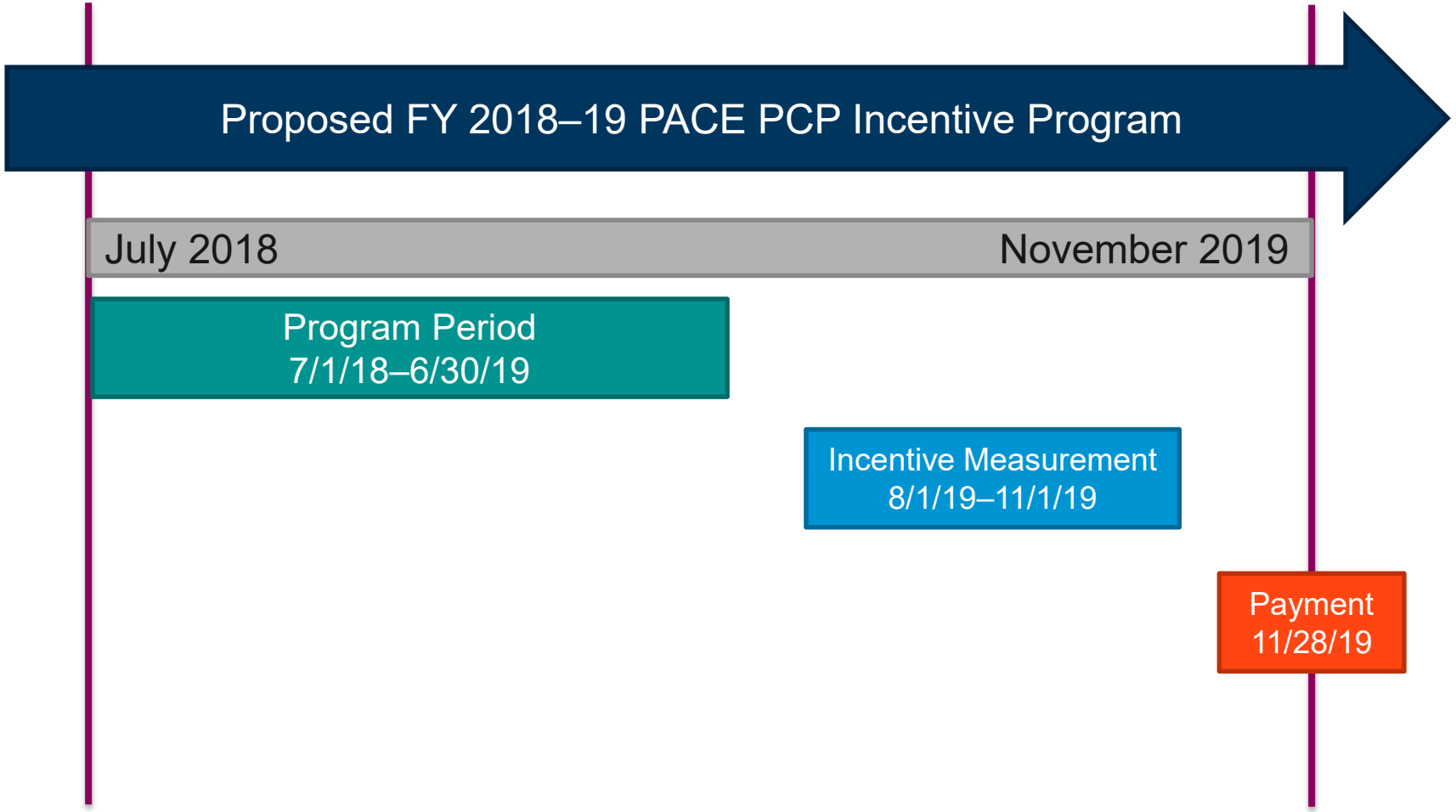
Proposed QI Incentive Elements

Elements	Current	Proposed
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	✓	✓
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	✓	✓
Coding Errors	✓	
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus tricyclic antidepressants or antipsychotics		✓
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia plus tricyclic antidepressant or anticholinergic agents		✓
Functional Status Assessment		✓
Total Potential QI Incentive	**$3 PMPM**	**$10 PMPM**

Proposed UM Incentive (Savings Sharing)

	Budget	Sharing by Tier Level		Cumulative Total Savings		PCP Role (Distribution by Tier)	
	100%	CalOptima	PCP	CalOptima	PCP	Non-clinic based (IP, ER, SNF, Home Visits)	Clinic-based
Tier 1	95%–100%	100%	0%	100%	$0	N/A	N/A
Tier 2	90%–95%	50%	50%	75%	25%	75%	25%
Tier 3	85%–90%	50%	50%	67%	33%	80%	20%
Tier 4	80%–85%	50%	50%	63%	38%	85%	15%
Tier 5 (Incentive Ends)	75%–80%	50%	50%	60%	40%	90%	10%

Proposed Timeline



Recommendation

- Specific to the CalOptima PACE Program, consider authorizing the Chief Executive Officer (CEO), with the assistance of Legal Counsel to:
  - Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
  - Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
  - Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contacts, including those of community-based physicians serving CalOptima PACE members.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

Fiscal Impact
It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation
As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Chambers — *10/28/11*
Authorized Signature — **Date**

CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

Back to Agenda Back to Item

2018-2019 CalOptima PACE PCP Incentive Program Grid

QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY	August	TruChart Analytics and Pharmacy Utliization Report. 2016 HEDIS Quality Compas 90th percentile is <37.50%.	>/=37.50%	$0 PMPM	January
					<37.50%	$2 PMPM	
QI: Functional Status Assessment	At a minimum, all participants need a complete Functional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$10	January

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda Back to Item

2018-2019 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail										Paid
UM; CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PCP care including real-time evaluations in the evenings and weeksends at the participant's homes, ER's and SNF's will be important in ensuring particiapnts gets timely, appropriate care. The structure of this program avoids any risk to the PCP.	FY 2019	Audited FY Performance	PCP receives % of the actual inpatient cost savings calculated from the audited FY financial.	Tier	Performance (% below Budget)	Maximum % Savings from Inpatient Budget	% of UM Savings to Cal Optima by Tier	% of UM Savings to PCPs by Tier	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Clinic-Based Services	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of UM Savigs to Cal Optima	Cumulative % of UM Savings to PACE PCP's UM Incentive	Nov-19
					Budget	100%								
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	**100%**	**0%**	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	**75%**	**25%**	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	**67%**	**33%**	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	**63%**	**38%**	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	**60%**	**40%**	

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center

Back to Agenda

Back to Item

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	Jan 1, 2018 to June 30th, 2018	Oct-18	The CalOptima Coding Department will audit 100% of the charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	Nov-18
					75-89%	$0.5 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	Jan 1, 2018 to June 30th, 2018	Audited FY Performance September 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $20 PMPM or $31,020***	Nov-18
					Incentive ends at BD / K / Y equivalent of 2,000		

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda Back to Item

2019-2020 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail										Paid
UM: CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PACE PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PACE PCP care including real-time evaluations in the evenings and weekends at the participant's homes, ER's and SNF's will be important in ensuring particiapnts gets timely, appropriate care.	FY 2019-2020	Audited FY Performance	PACE PCPs receives percentage of the actual inpatient cost savings calculated from the audited FY financials.	Tier	Performance (% below Budget)	Total % Savings from Inpatient Budget	% of UM Cost Savings to CalOptima by Tier	% of UM Cost Savings to PACE PCPs by Tier	% of PACE PCP UM Cost Savings to PACE PCPs performing Clinic-Based Services	% of PACE PCP UM Cost Savings to PACE PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of Inpatient UM Cost Savings to CalOptima	Cumulative % of Inpatient UM Savings to PACE PCPs	January
					Budget	100%								
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	**100%**	**0%**	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	**75%**	**25%**	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	**67%**	**33%**	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	**63%**	**38%**	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	**60%**	**40%**	

PACE Community PCP's will be eligible for the UM Incentive based on the member months of the members assigned to them.

PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.

Individual PACE PCP Clinic-Based Incentives will be calculated based on the number of hours worked at the PACE center

Back to Agenda

Back to Item

2019-2020 PACE PCP QI Incentive Grid

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
QI: Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	FY 2019-2020	October (2019 Survey resuls equals 25% of score and 2020 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<89%	$0 PMPM	January
					>/= 89%	$1 PMPM	January
					>/= 92%	$2 PMPM	January
QI: Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	FY 2019-2020	October (2019 Survey resuls equals 25% of score and 2020 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 88%	$0 PMPM	January
					>/= 88%	$1 PMPM	January
					>/= 92%	$2 PMPM	January
QI: Comprehensive Diabetes Care	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	FY 2019-2020	August	>80.12% of Diabetics will have a Blood Pressure of <140/90 (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	>80.12%	$1.50 PMPM	January
				> 83.54% of Diabetics will have an Annual Eye Exam (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	>83.54%	$1.50 PMPM	January
				>98.38% of Diabetics will have Nephropathy Monitoring (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	>98.38%	$1.50 PMPM	January
QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY 2019-2020	August	TruChart Analytics and Pharmacy Utliization Report. 2017 HEDIS Quality Compas (75th percentile is 40.61% and 90th percentile is <36.13%).	>40.61%	$0 PMPM	January
					36.13% to 40.61%	$1 PMPM	
					<36.13%	$2 PMPM	
QI: Functional Status Assessment	At a minimum, all participants need a complete Functional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY 2019-2020	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$12.50	January

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.

PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.

Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center

*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".

** Computed as a weighted average of participant satisfaction for ten domains.

Back to Agenda Back to Item

2020-2021 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail										Paid
UM: CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PACE PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PACE PCP care including real-time evaluations in the evenings and weekends at the participant's homes, ER's and SNF's will be important in ensuring particiapnts gets timely, appropriate care.	FY 2020-2021	Audited FY Performance	PACE PCPs receives percentage of the actual inpatient cost savings calculated from the audited FY financials.	Tier	Performance (% below Budget)	Total % Savings from Inpatient Budget	% of UM Cost Savings to CalOptima by Tier	% of UM Cost Savings to PACE PCPs by Tier	% of PACE PCP UM Cost Savings to PACE PCPs performing Clinic-Based Services	% of PACE PCP UM Cost Savings to PACE PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of Inpatient UM Cost Savings to CalOptima	Cumulative % of Inpatient UM Savings to PACE PCPs	January
					Budget	100%								
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	**100%**	**0%**	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	**75%**	**25%**	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	**67%**	**33%**	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	**63%**	**37%**	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	**60%**	**40%**	

PACE Community PCP's will be eligible for the UM Incentive based on the member months of the members assigned to them.

PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.

Individual PACE PCP Clinic-Based Incentives will be calculated based on the number of hours worked at the PACE center

Back to Agenda

Back to Item

2020-2021 PACE PCP QI Incentive Grid

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
QI: Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	FY 2020-2021	October (2020 Survey resuls equals 25% of score and 2021 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<89%	$0 PMPM	January
					>/= 89%	$1 PMPM	January
					>/= 92%	$2 PMPM	January
QI: Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	FY 2020-2021	October (2019 Survey resuls equals 25% of score and 2020 Survey results equals 75% of score.)	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 88%	$0 PMPM	January
					>/= 88%	$1 PMPM	January
					>/= 92%	$2 PMPM	January
QI: Comprehensive Diabetes Care***	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	FY 2020-2021	August	>80.21% of Diabetics will have a Blood Pressure of <140/90 (MEDICARE Quality Compass - 2018 HEDIS 90th percentile)	>80.21%	$1.50 PMPM	January
				> 84.54% of Diabetics will have an Annual Eye Exam (MEDICARE Quality Compass - 2018 HEDIS 90th percentile)	>84.54%	$1.50 PMPM	January
				>98.54% of Diabetics will have Nephropathy Monitoring (MEDICARE Quality Compass - 2018 HEDIS 90th percentile)	>98.54%	$1.50 PMPM	January

Back to Agenda

Back to Item

QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents***	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY 2020-2021	August	TruChart Analytics and Pharmacy Utliization Report. MEDICARE Quality Compass 2018 HEDIS (75th percentile is 40.68% and 90th percentile is <37.31%).	>40.61%	$0 PMPM	January
					37.31% to 40.68%	$1 PMPM	
					<37.31%	$2 PMPM	
QI: Functional Status Assessment	At a minimum, all participants need a complete Functional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY 2020-2021	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$12.50 PMPM	January

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.

PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.

Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center

*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".

** Computed as a weighted average of participant satisfaction for ten domains.

*** Exlusions defined in 2020 PACE Quality Improvement Plan

Back to Agenda Back to Item

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Janine Chamberlin	380 W. Central Ave.	Brea	CA	92821
John N. Le	27800 Medical Center Rd.	Mission Viejo	CA	92691
Lindsay E. Mossinger	3851 Katella Ave.	Los Alamitos	CA	90720
Dat Q. Nguyen	12865 Main St.	Garden Grove	CA	92840
Avni B. Pandya	12362 Beach Blvd.	Stanton	CA	90680
Viney Soni	9940 Talbert Ave.	Fountain Valley	CA	92708

Back to Agenda Back to Item

A Public Agency

PACE

CalOptima

Better. Together.

Program of All-Inclusive Care for the Elderly

PACE Primary Care Provider Incentive

Board of Directors Meeting
September 3, 2020

Miles Masatsugu, M.D., Medical Director

Back to Agenda

Back to Item

Overview of PACE

- To be eligible for the Program of All-inclusive Care for the Elderly (PACE), a participant must be:
  - 55 years or older
  - Resident of a PACE service area
  - Certified to need nursing facility level care
  - Able to live safely in community
- PACE serves the frailest seniors
  - Average age is greater than 80 years
  - Multiple chronic medical conditions
  - High level of functional dependencies (need help bathing, walking, toileting, etc.)

Background

- PACE established the PACE Primary Care Provider (PCP) Incentive Program in September 2017
- At that time, PACE did not have a pay-for-value or savings sharing program
- The incentive program has two components:
  - Pay-for-value quality improvement (QI) component with a potential maximum of $12.50 per member per month (PMPM)
  - An inpatient savings sharing utilization component

Background (cont.)

- Inpatient care is one of the largest costs for PACE
- The frail population and unfamiliarity with PACE leads to unnecessary hospitalizations
- The program covers all of Orange County and utilizes one main group of providers to provide inpatient services across the entire county to provide enhanced coordination of care

Board Actions

- On September 7, 2017, the Board authorized staff to establish a PACE PCP incentive program for the UCI Irvine PACE PCPs
- On June 7, 2018, the Board authorized the expansion of the incentive program to all PACE PCPs
- On August 1, 2019, the Board authorized the renewal of the incentive program with slight revisions to the QI component

QI Components

- Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care
- Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction
- Comprehensive Diabetes Care
  - Annual Diabetic Eye Exams
  - Nephropathy Monitoring
  - Blood Pressure Control
- Potential Harmful Drug/Disease Interactions in the Elderly: Dementia plus a Tricyclic Antidepressant or Anticholinergic Agent
- Functional Status Assessment Completion

2019 Annual Participant Satisfaction Survey Results

Domain	2018 CalOptima PACE	2019 CalOptima PACE	2019 CalPACE Average	2019 National PACE Average
Transportation	93%	**96%**	92%	94%
Center Aids	92%	**94%**	91%	91%
Home Care	91%	**89%***	87%	87%
Medical Care	**88%**	**93%**	**91%**	**91%**
Health Care Specialist	90%	**98%**	90%	90%
Social Worker	97%	**96%***	95%	95%
Meals	59%	**77%**	71%	71%
Rehabilitation Therapy and Exercise	98%	**98%**	93%	94%
Recreational Therapy	77%	**91%**	81%	81%
Environment and Safety	92%	**93%**	88%	88%
Overall Weighted Score	**87%**	**92%**	**89%**	**89%**

* Decrease from 2018

Back to Agenda

Back to Item

CalOptima
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2019 Comprehensive Diabetes Care Results

Higher Is Better		Medicare Quality Compass 2018 HEDIS Percentiles			
Domain	**2019 PACE Rate**	**50th Percentile**	**75th Percentile**	**90th Percentile**	**95th Percentile**
Annual Diabetic Exams	**95%**	75.28%	82%	85.33%	**87.10%**
Nephropathy Monitoring	**99%**	95.95%	97.08%	98.30%	**98.78%**
Blood Pressure Control	**84%**	69.53%	76.56%	81.50%	**84.91%**

Back to Agenda

Back to Item

CalOptima
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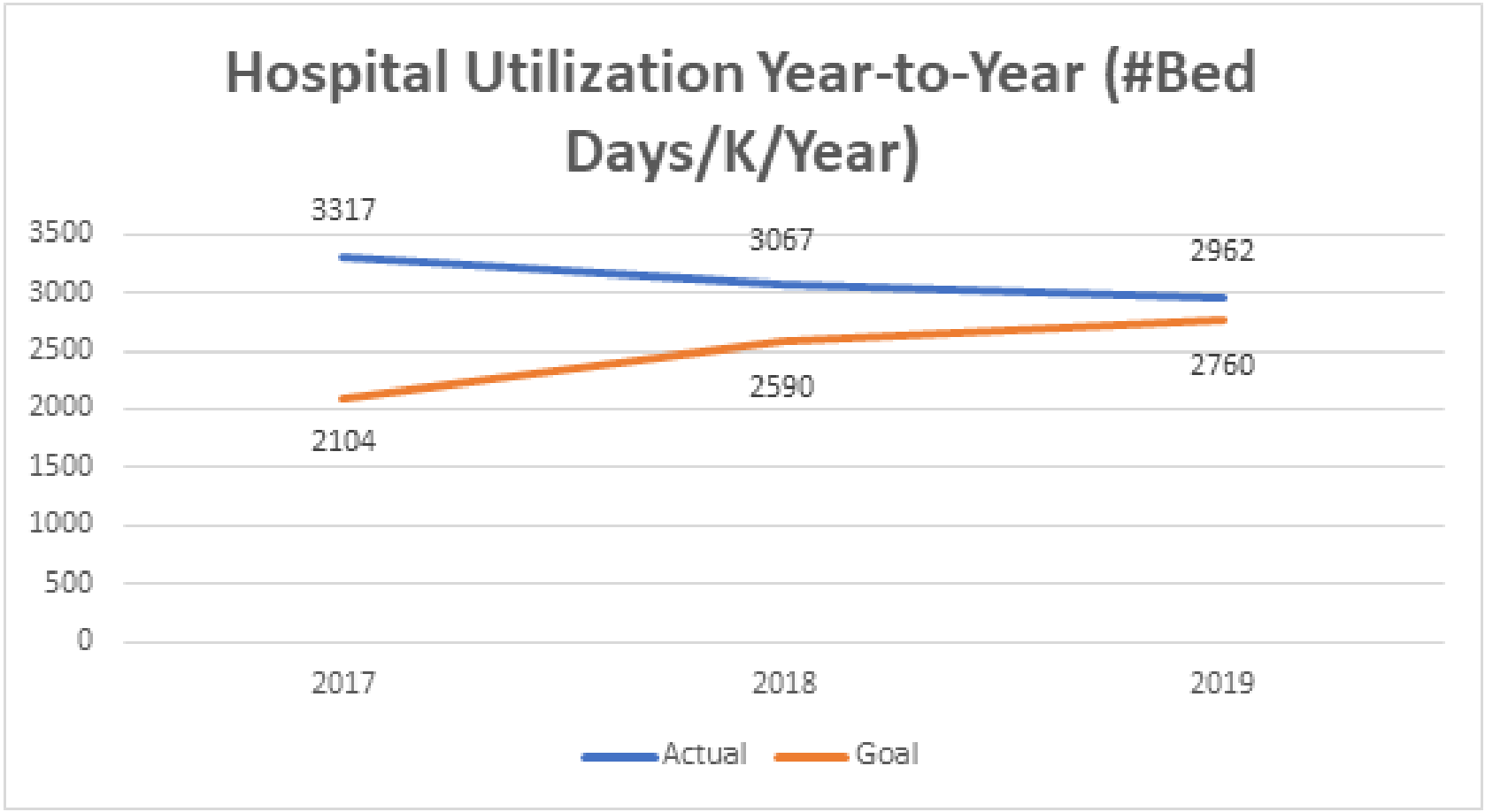
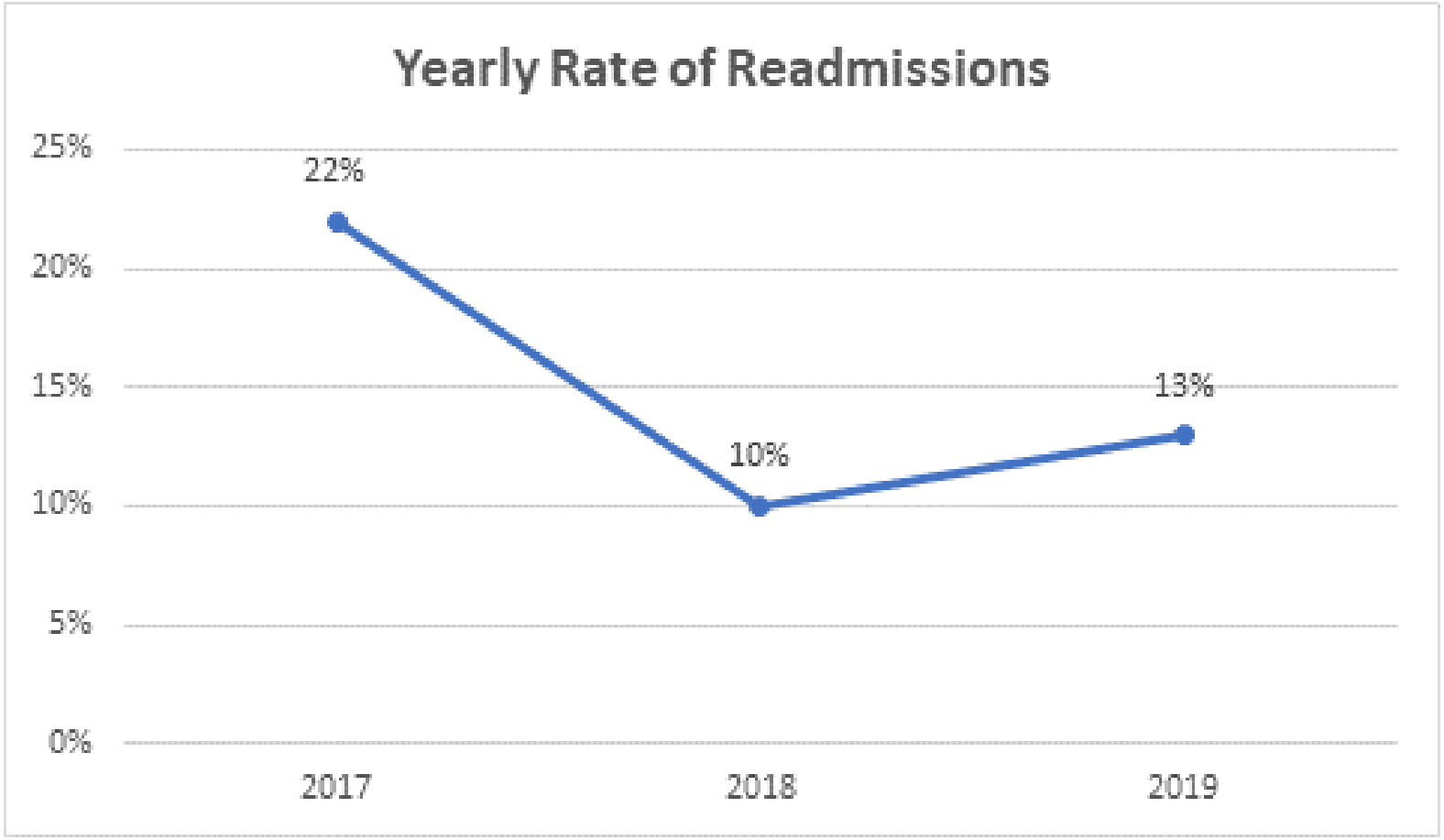
Hospital Bed Day Trends (2017–2019)



30-Day All-Cause Readmissions (2017–2019)



Back to Agenda
Back to Item

CalOptima
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QI Component Results

- Participant Satisfaction
  - #1 in overall participant satisfaction of all PACE plans in California
  - Better than state and national averages in all 10 participant satisfaction domains
  - Year-over-year improvement in participant satisfaction with medical care and overall participant satisfaction
- Comprehensive Diabetes Care
  - Rate of annual diabetic eye exams and nephropathy monitoring comparable to the Medicare Quality Compass Healthcare Effectiveness Data and Information Set (HEDIS) 95th percentile
  - Rate of blood pressure control in diabetes comparable to the Medicare Quality Compass HEDIS 90th percentile

QI Component Results (cont.)

- Potential Harmful Drug/Disease Interactions in the Elderly
  - Rate of dementia plus a tricyclic antidepressant or anticholinergic agent comparable to the Medicare Quality Compass HEDIS 95th percentile
- Functional Status Assessment Completion
  - 100% completed

Utilization Management (UM) Component Results

- Inpatient bed days year-over-year improvement since the onset of the incentive program
- Maintained the low 30-day all-cause readmission rate improvements made in 2018
- Additionally, since the pandemic began in February/March of 2020, our providers have seen a(n):
  - 98% increase in after-hours/weekends telehealth evaluations
  - 8% increase in the after-hours/weekends home visits/evaluations

Proposed 2020–2021 QI Incentive Elements

Elements		PMPM
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care		$2
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction		$2
Comprehensive Diabetes Care	Annual Diabetic Eye Exam	$1.50
	Nephropathy Monitoring	$1.50
	Blood Pressure Control	$1.50
Potential Harmful Drug/Disease Interactions in the Elderly: Dementia Plus a Tricyclic Antidepressant or Anticholinergic Agent		$2
Functional Status Assessment Completion		$2
Total Potential QI Incentive		$12.50 PMPM

Back to Agenda

Back to Item

CalOptima
A Public Agency

Proposed UM Incentive (Cost Savings Sharing)

	Budget	Sharing by Tier Level		PCP Role (Distribution by Tier)		Cumulative Total Savings	
	100%	CalOptima	PCP	Non-clinic based (IP, ER. SNF, Home Visits)	Clinic-based	CalOptima	PCP
Tier 1	95–100%	100%	0%	N/A	N/A	100%	0%
Tier 2	90–95%	50%	50%	75%	25%	75%	25%
Tier 3	85–90%	50%	50%	80%	20%	67%	33%
Tier 4	80–85%	50%	50%	85%	15%	63%	37%
Tier 5 (Incentive Ends)	75–80%	50%	50%	90%	10%	60%	40%

Back to Agenda

Back to Item

CalOptima
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Next Steps

- Recommend the Board authorize the renewal of the PACE PCP Incentive Program and related changes to PCP contracts.

Our Mission

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Actions Related to Intergovernmental Transfer (IGT) 5 Community Grant Contract(s) in Response to COVID-19

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the contract with IGT 5 community grantee Korean Community Services, Inc. (KCS) to allow for a no-cost time extension to the grant through no later than October 31, 2021 for the purpose of allowing KCS more time for completing workplan deliverables.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in nine Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received and IGT 10 funds are expected from the state beginning in the Spring of 2021. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2010-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to the Centers for Medicare & Medicaid Services (CMS). Beginning with IGT 8, the state views the IGT payments as part of the capitation CalOptima receives in exchange for ensuring that assigned Medi-Cal beneficiaries have access to covered, medically necessary health care services, with all expenditures of the IGT funds not qualifying as medical expenses counted as part of CalOptima's administrative expenses.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet health care needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless CalOptima members, and support for members through the Personal Care Coordinator (PCC) program. These funds have typically been used for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.
On August 1 and October 3, 2019, the CalOptima Board of Directors (Board) authorized community grants funded through IGT 5, 6 and 7 in seven priority areas:

- Expand Access to Outpatient Children's Mental Health Services;
- Integrate Children's Mental Health Services into Primary Care;
- Increase Access to Medication-Assisted Treatment;
- Expand Access to Food Distribution Services Focused on Children and Families;
- Access to Children's Dental Services;
- Access to Adult Dental Services; and
- Primary Care Services and Programs Addressing Social Determinants of Health.

Back to Agenda

Twelve community grants were awarded to 11 organizations, with one organization receiving two grants in separate categories.

On February 27, 2020, Orange County declared a local health emergency related to COVID-19 and the Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus. While social distancing has been encouraged to limit the spread of COVID-19, beginning March 17, 2020 local and state agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside a list of "essential activities". Subsequently, CMS recommended that all elective surgeries, non-essential medical, surgical and dental procedures should be delayed during the pandemic. In response, CalOptima staff distributed a general message on March 26, 2020 to the grantees acknowledging COVID-19 might have a potential impact on the deliverables for each grant. Staff also conducted calls with grantees to discuss how the crisis has impacted their organization and the grant deliverables, and if any steps are being considered to address potential delays or issues caused by the crisis

Discussion

Due to the stay-at-home orders and regulatory guidance, most of the IGT grantees have had to curtail or modify grant activities until after the current emergency is over. In response, on June 4, 2020 the Board approved no-cost time extensions, temporary modifications to the Scope of Work, and/or revisions to budget line item requests for IGT grantees. Included in the June 4, 2020 Board action, Korean Community Services, Inc. (KCS) received approval for a temporary modification of CalOptima's $1 million grant award to expand the Scope of Work to implement tele-dentistry services. At that time, KCS leadership believed that the modification to the Scope of Work would allow KCS to continue to meet other program deliverables during the COVID-19 crisis. However, under the current circumstances, with the State reinstating closures once again and community outreach being placed on hold, as well as member inexperience with tele-dentistry and reluctance to receive in-office dental services, KCS is requesting modification of the KCS IGT 5 grant contract to also include a no-cost extension. CalOptima staff recommends extending the end date of the grant through no later than October 31, 2021.

Fiscal Impact

The recommended action to amend the contract with an IGT 5 community grantee has no additional fiscal impact to IGT expenditures, as authorized by Board action dated August 1, 2019. IGT funds are for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and do not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends that the Board allow additional time for an IGT 5 grantee to complete scope of work deliverables due to delays caused by the COVID-19 pandemic.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by the Recommended Action
2. CalOptima Board Action dated June 4, 2020, Consider Actions Related to Intergovernmental Transfer (IGT) 5, 6 and 7 Community Grant Contracts in Response to COVID-19

/s/ Richard Sanchez *08/26/2020*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
KCS Health Center (Korean Community Services)	7212 Orangethorpe Ave., Ste 9A	Buena Park	CA	90621

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action(s)

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend contract agreements with IGT 5, 6 and 7 community grantees to allow for the following when applicable:

a. No-Cost time extension to the grants for the purpose of completing workplan deliverables;
b. Temporary modifications to the Scope of Work to include a modified delivery of service when the request does not impact the objective or number of members served; and/or
c. Revisions to the budget line item due to statutory changes; changes in direct response to COVID-19 new guidelines, or to address the temporary modification in Scope of Work.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in nine Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received and IGT 10 funds are expected from the state in the first quarter of 2022. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2010-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to the Centers for Medicare & Medicaid Services (CMS).

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet health care needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless CalOptima members, and support for members through the Personal Care Coordinator (PCC) program. These funds have typically been used for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.
On August 1 and October 3, 2019, the CalOptima Board of Directors authorized community grants funded through IGT 5, 6 and 7 in seven priority areas:

- Expand Access to Outpatient Children's Mental Health Services;
- Integrate Children's Mental Health Services into Primary Care;
- Increase Access to Medication-Assisted Treatment;
- Expand Access to Food Distribution Services Focused on Children and Families;
- Access to Children's Dental Services;
- Access to Adult Dental Services; and
- Primary Care Services and Programs Addressing Social Determinants of Health.

Back to Agenda Back to Item

Twelve community grants were awarded to 11 organizations, with one organization receiving two grants in separate categories.

On February 27, 2020, Orange County declared a local health emergency related to COVID-19 and the Governor of California declared a State of Emergency on March 4, 2020. On March 11, 2020, the World Health Organization declared the coronavirus a pandemic. On March 13, 2020, the President declared a national emergency based on the spread of the coronavirus. While social distancing has been encouraged to limit the spread of COVID-19, beginning March 17, 2020 local and state agencies began implementing stay-at-home orders to prohibit professional, social, and community gatherings outside a list of "essential activities". Subsequently, CMS announced that all elective surgeries, non-essential medical, surgical, and dental procedures be delayed during the pandemic. In response, CalOptima staff distributed a general message on March 26, 2020 to the grantees acknowledging COVID-19 might have a potential impact on the deliverables for each grant.

Discussion

Due to the stay-at-home orders and regulatory guidance, most of the IGT grantees have had to curtail grant activities on new initiatives to focus efforts to respond to the immediate crisis until after the current emergency is over. CalOptima staff conducted calls with grantees to discuss how the crisis has impacted their organization and the grant deliverables, and if any steps are being considered to address potential delays or issues caused by the crisis. As a result, staff has received requests for accommodations of their grant agreements, that include:

- No-cost extensions: Extend due dates for deliverables and grant completion at no additional costs until the grantee is able to resume services based on orders or guidelines set forth by Federal, State, or Local authorities and grantee organizational capacities;
- Revised budget line items: Move budgeted amounts between line items with no change to the overall budget; and/or
- Temporary modifications to scope of work: Modifications to the scope of work to allow for different modes of providing deliverables, such as temporarily providing telehealth or teledentistry in lieu of in-person care.

Based on the requests from the grantees, staff proposes below actions for the following grantees, where indicated, to address the impact to the grant deliverables:

Funding Category	IGT #	Grantee	Project Length	Contract Start Date	Total Grant Amount	Recommended Action(s)
1. Children's Dental Services	5	Coalition of Orange County Community Health Centers	2 years	10/1/2019	$500,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19

	Funding Category	IGT #	Grantee	Project Length	Contract Start Date	Total Grant Amount	Recommended Action(s)
2.	**Children's Dental Services**	5	Healthy Smiles for Kids of Orange County	1 year	2/1/2020	$500,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
3.	**Primary Care Services and Social Determinants of Health**	5	Santa Ana Unified School District	3 years	10/1/2019	$1,400,000	No specific action requested at this time
4.	**Adult Dental Services**	5	KCS Health Center (Korean Community Services)	1 year	10/1/2019	$1,000,000	Provide temporary modification in Scope of Work to allow alternate delivery of service (tele-dentistry) due to regulatory guidelines as a result of COVID-19
5.	**Outpatient Children's Mental Health Services**	6/7	Children's Bureau of Southern California	2 years	12/1/2019	$3,390,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
6.	**Outpatient Children's Mental Health Services**	6/7	Orange County Asian & Pacific Islander Community Alliance, Inc (OCAPICA)	3 years	10/1/2019	$685,000	No specific action requested at this time
7.	**Outpatient Children's Mental Health Services**	6/7	Boys & Girls Clubs of Garden Grove	3 years	10/1/2019	$325,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
8.	**Outpatient Children's Mental Health Services**	6/7	Jamboree Housing Corporation	2 years	10/1/2019	$450,000	No specific action requested at this time
9.	**Integrate Children's Mental Health Services**	6/7	CHOC Children's	3 years	10/1/2019	$4,250,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19

Funding Category	IGT #	Grantee	Project Length	Contract Start Date	Total Grant Amount	Recommended Action(s)
10. Integrate Children's Mental Health Services	6/7	Friends of Family Health Center	2 years	10/1/2019	$600,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19
11. Increase Access to MAT	6/7	Coalition of Orange County Community Health Centers	3 years	10/1/2019	$6,000,000	Provide no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19 and budget line item revision due to a recent change in regulatory guidelines that eliminated an added procurement expense for the drug Narcan
12. Food Distribution Services Children and Families	6/7	Serve the People	2 years	10/1/2019	$1,000,000	Provide temporary modification in Scope of Work to allow for home delivery, budget line item revision to allow for the purchase of food, and no-cost extension of contract term in order to meet deliverables due to delays as a result of COVID-19

Fiscal Impact

The recommended action to amend contract agreements with IGT 5, 6, and 7 community grantees has no additional fiscal impact to IGT expenditures, as authorized through previous Board actions. IGT funds are for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's commitment in working Better. Together, and as the Medi-Cal health plan for Orange County, CalOptima continues to work with our provider and community partners to address the needs of our members, by working to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by the Recommended Action
2. CalOptima Board Action dated August 1, 2019, Consider Allocation of Intergovernmental Transfer 6 and 7 Funds
3. CalOptima Board Action dated August 1, 2019, Consider Allocation of Intergovernmental Transfer 5 Funds
4. CalOptima Board Action dated October 3, 2019, Consider Allocation of Intergovernmental (IGT) 5 Funds Towards a Community Grant(s) for Access to Children's Dental Services

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

Back to Agenda

Back to Item

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

	Name	Medical Group	Address	City	State	Zip Code
1.	Boys & Girls Clubs of Garden Grove	NA	10540 Chapman Ave.	Garden Grove	CA	92840
2.	Children's Bureau of Southern California	NA	50 Anaheim Blvd. Ste. 241	Anaheim	CA	92805
3.	CHOC Children's	CHOC Health Alliance	1201 W. La Veta Ave.	Orange	CA	92868
4.	Coalition of Orange County Community Health Centers*	NA	515 N. Cabrillo Dr. Ste. 225	Santa Ana	CA	92701
5.	Friends of Family Health Center		501 South Idaho Street	La Habra	CA	90631
6.	Healthy Smiles for Kids Orange County	NA	10602 Chapman Ave. Ste. 200	Garden Grove	CA	92840
			2010 E. Fourth Street, Ste. A220	Santa Ana	CA	92705
7.	Jamboree Housing Corporation	NA	17701 Cowan Ave., Ste. 200	Irvine	CA	92614
8.	KCS Health Center (Korean Community Services)		7212 Orangethorpe Ave. Ste 9A	Buena Park	CA	90621
9.	Orange County Asian & Pacific Islander Community Alliance, Inc	NA	12912 Brookhurst Street Ste. 410	Garden Grove	CA	92840
10.	Santa Ana Unified School District	NA	1061 East Chestnut Ave.	Santa Ana	CA	92701
11.	Serve the People		1206 17th Street	Santa Ana	CA	92701

Back to Agenda

Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Allocation of Intergovernmental Transfer 6 and 7 Funds

Contact
Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1 million for community grants and internal projects; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1 – 7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On August 3, 2017, CalOptima's Board of Directors approved the recommendation to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

Subsequently, CalOptima released Requests for Information/Letters of Interest (RFI/LOI) from organizations to help determine funding allocation amounts for the priority areas and received 117 responses. Initial projections of available IGT 6/7 funds were estimated to be $22.1 million.

In May 2018, CalOptima received final IGT 6 and 7 funding from the Department of Health Care Services (DHCS), resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. On August 2, 2018, the Board approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program. On September 6, 2018 the Board authorized the remaining available balance of $21.1 million to be used for community grants, internal initiatives and program administration.

Back to Agenda Back to Item

Subsequently, at its February 22, 2019 Special Meeting, the Board approved funds to be reallocated to the Clinical Field Teams Pilot for the Homeless Health Initiatives. The funds were reallocated from Requests for Proposals (RFP) 4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) in the total amount of $1 million which were not recommended for grants. In addition, $100,000 IGT 6 funds previously approved by the Board were reallocated from Internal Initiatives to the Clinical Field Teams Pilot. The reallocations were ratified at the April 4, 2019 Board meeting.

Proposed Allocation for community grants and internal initiatives is as follows:

Community Grants

Request for Proposal	Priority Area	Allocation Amount
1. Access to Outpatient Mental Health Services	Children's Mental Health	$4,850,000
2. Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	$4,850,000
3. Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000
4. Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
5. Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA	$1,000,000
6. Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA	Allocated to the Homeless Health Initiatives
TOTAL		**$16,700,000**

Internal Initiatives

Internal Project Examples: - IS and other infrastructure projects as summarized below.	$2,400,000
TOTAL	**$2,400,000**

External subject matter experts and staff performed an examination of the RFP 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 IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do and Director DiLuigi, met to discuss the results of the 54 RFP responses for the Children's Mental Health and Opioid and Other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the evaluation committees results and RFP recommendations, the Ad Hoc committee is recommending the following allocation of approximately $16.7 million for IGT 6 and 7 Board-approved priority areas through four (4) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	Children's Bureau of Southern California	$3,390,000
	OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$685,000
	Boys & Girls Clubs of Garden Grove	$325,000
	Jamboree Housing	$450,000
RFP 2. Integrate Children's Mental Health Services into Primary Care ($4.85 million)	CHOC Children's	$4,250,000
	Friends of Family Health Center	$600,000
RFP 3. Increase Access to Medication-Assisted Treatment ($6 million)	Coalition of Orange County Community Health Center	$6,000,000
RFP 5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	Serve the People	$1,000,000
TOTAL		**$16,700,000**

As noted above, the ad hoc is not recommending grants for two of the RFP categories (4. Expand Mobile Food Distribution Services and 6. Expand Access to Food Distribution for Older Adults) and the associated funding was previously reallocated to the Clinical Field Teams Pilot at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Internal Initiatives
In addition, staff reviewed four internal applications and is recommending an allocation of $2.4 million for internal projects. Funding of $100,000 from the Internal Initiatives budget was reallocated to the Clinical Field Team pilot for the Homeless Health Initiatives at the February 22, 2019 Special Meeting of the CalOptima Board of Directors.

Project	Amount
Whole Child Model Assistance for Implementation and Development (WCM AID)	$1,750,000
Master Electronic Health Record (EHR) System	$650,000
TOTAL	**$2,400,000**

Fiscal Impact
The recommended action to approve the allocation of $19.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, will work with our provider and community partners to address the health care needs of the members we serve.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: IGT 6 and 7 Expenditure Plan Allocation
2. CalOptima Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7
3. CalOptima Board Action dated August 2, 2018, Consider Approval of Grant Allocations of Intergovernmental Transfer (IGT) 6 and 7 Fund
4. CalOptima Board Action dated September 6, 2018, Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants
5. CalOptima Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but no limited to, Funding and Provider Contracting
6. IGT 6/7 RFP Responses

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda Back to Item

Back to Agenda

Back to Item

IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

Background

Back to Agenda

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population

Back to Item

- CalOptima Board of Directors approved IGT 6 and 7 priority areas for community-based funding opportunities
  - Children's Mental Health
  - Homeless Health
  - Opioid and Other Substance Overuse
  - Other Needs Identified by the Member Health Needs Assessment

Background (cont.)

Back to Agenda

- Received 117 RFIs to identify strategies for each priority area
- IGT 6 and 7 funds of $31.1 million were received in May 2018
  - $10 million approved for recuperative care services in August 2018
  - $21.1 million allocated for community grants, internal initiatives and program administration in September 2018
    - $17.7 million in community grants
    - $2.5 million in internal initiatives
    - $900,000 in program administration (over 3 years)
- Released RFPs, evaluated responses and conducted site visits from September 2018–January 2019

Back to Item

RFP Evaluation Criteria

Back to Agenda

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Back to Item

Site Visits

Back to Agenda

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

Back to Item

RFP Summary

Back to Agenda

RFP	Total Received	Total Recommended
1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)	26	4
2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)	10	2
3. Increase Access to Medication-Assisted Treatment ($6 million)	10	1
4. Expand Mobile Food Distribution Services ($500,000)	1	0
5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)	5	1
6. Expand Access to Food Distribution Services for Older Adults ($500,000)	2	0
Total	**54**	**8**

Back to Item

1. Expand Access to Outpatient Children's Mental Health Services ($4.85 million)

Back to Agenda

Rank	Organization	Original Request	Recommended Funding Amount
1	Children's Bureau of Southern California	$3,500,000	$3,390,000
2	OCAPICA (Orange County Asian & Pacific Islander Community Alliance Inc.)	$685,000	$685,000
3	Boys & Girls Club of Garden Grove	$325,200	$325,000
4	Jamboree Housing	$692,000	$450,000
	Total	**$5,202,200**	**$4,850,000**

Back to Item

2. Integrate Children's Mental Health Services Into Primary Care ($4.85 million)

Back to Agenda

Rank	Organization	Original Request	Recommended Funding Amount
1	CHOC Children's	$4,785,076	$4,250,000
2	Friends of Family Health Center	$600,000	$600,000
	Total	**$5,385,076**	**$4,850,000**

Back to Item

3. Increase Access to Medication-Assisted Treatment ($6 million)

Back to Agenda

Rank	Organization	Original Request	Recommended Funding Amount
1	Coalition of Orange County Community Health Centers	$5,998,000	$6,000,000
	Total	**$5,998,000**	**$6,000,000**

Back to Item

5. Expand Access to Food Distribution Services Focused on Children and Families ($1 million)

Back to Agenda

Rank	Organization	Original Request	Recommended Funding Amount
1	Serve the People	$1,000,000	$1,000,000
	Total	**$1,000,000**	**$1,000,000**

Back to Item

No Funding for RFPs 4 and 6

Back to Agenda

- No funding is recommended for two RFPs
  - 4. Expand Mobile Food Distribution Services ($500,000)
  - 6. Expand Access to Food Distribution Services for Older Adults ($500,000)
- Submitted proposals presented challenges
  - Did not demonstrate delivery of service to CalOptima members
  - Did not demonstrate sustainability after funds exhausted
- Funding was allocated to the Homeless Health Initiative's Clinical Field Team pilot on February 22, 2019

Back to Item

Internal Projects ($2.4 million)

Back to Agenda

Rank	Project	Original Request	Recommended Funding Amount
1	Whole-Child Model Assistance for Implementation and Development	$1,750,000	$1,750,000
2	Master Electronic Health Record (EHR) System	$700,000	$650,000
	Total	**$2,450,000**	**$2,400,000**

Back to Item

Recommended Board Actions

Back to Agenda

- Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1M for community grants and internal projects; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

Back to Item

CalOptima's Mission

Back to Agenda

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

Back to Item

Back to Agenda

Back to Item

Back to Agenda

Back to Item

Back to Agenda

IGT Update & Proposed Funding Categories for IGT 6 & 7

Back to Item

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

Back to Agenda

Back to Agenda
Back to Item

Intergovernmental Transfers (IGT) Background

Back to Agenda

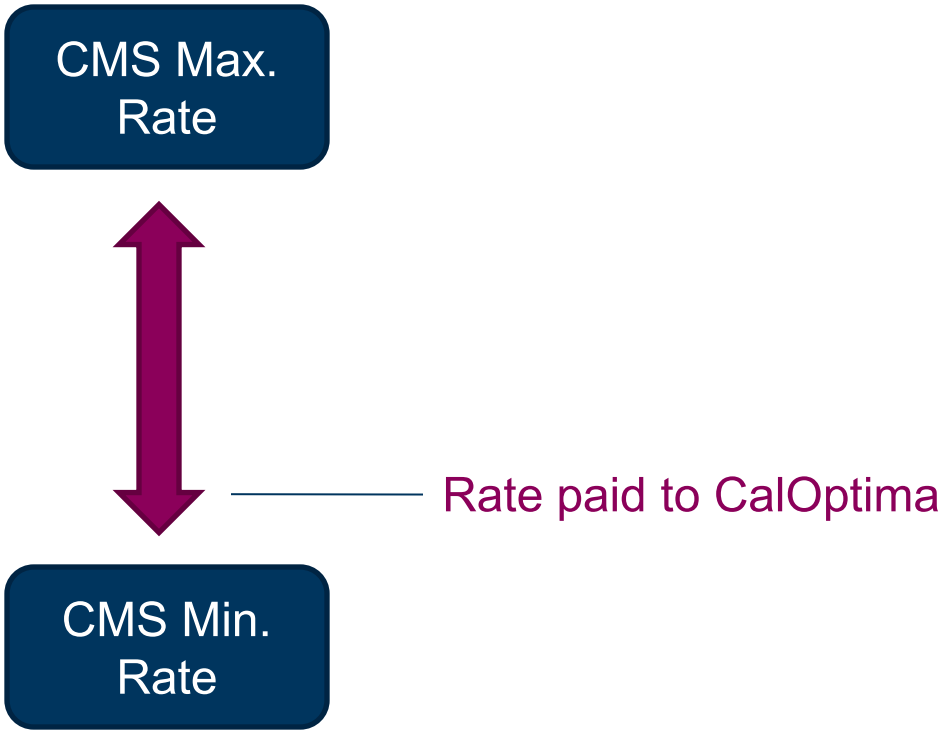
- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

Back to Item

Low Medi-Cal Managed Care Rates

Back to Agenda

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



Back to Item

IGT Funds Availability and Process

Back to Agenda

- 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

Back to Item

- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

CalOptima Share Totals To-Date

Back to Agenda

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

Back to Item

IGT 1 Status

Back to Agenda

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

Back to Item

As of 5/31/2017

Back to Agenda

Back to Agenda
Back to Item

CalOptima A Public Agency Better. Together.

IGT 2 Status

Back to Agenda

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

Back to Item

As of 5/31/2017

Back to Agenda

Back to Agenda
Back to Item

CalOptima A Public Agency Better. Together.

IGT 3 Status

Back to Agenda

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

Back to Item

As of 5/31/2017

Back to Agenda

Back to Agenda
Back to Item

CalOptima A Public Agency Better. Together.

IGT 4 Status

Back to Agenda

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

As of 5/31/2017

Back to Item

Back to Agenda

Back to Agenda

Back to Item

CalOptima A Public Agency Better. Together.

IGT 5

Back to Agenda

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

Back to Item

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

Member Health Needs Assessment (IGT 5)

Back to Agenda

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

Back to Item

Member Health Needs Assessment (IGT 5)

Back to Agenda

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

Back to Item

Estimated IGT 6 and 7 Totals

Back to Agenda

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

Back to Item

Proposed IGT Funding Categories - IGT 6 and 7

Back to Agenda

- Funds to be used to deliver enhanced services for the Medi-Cal population

Back to Item

Opioid/Other Substances Overuse

Back to Agenda

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome

Back to Item

- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

Back to Agenda

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

Back to Item

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

Homeless Health

Back to Agenda

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs

Back to Item

- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

Competitive Community Grants

Back to Agenda

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

Back to Item

CalOptima Projects and Program Admin

Back to Agenda

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

Back to Item

Next Steps

Back to Agenda

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

Back to Item

CalOptima's Mission

Back to Agenda

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

Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

Back to Agenda Back to Item

Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

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 benefits 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 Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

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

Contact
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve an additional grant allocation of up to $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services-approved and Board-approved Intergovernmental Transfer 6 and 7 Homeless Health priority area;
2. Replace the current cap of $150 on the daily rate and the 15-day stay maximum paid out of CalOptima funds with a 50/50 cost split arrangement with the County for stays of up to 90 days for homeless CalOptima members referred for medically justified recuperative care services under OCHCA's Whole Person Care Pilot program; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the grant agreement with the County of Orange to include indemnity language and allow for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program; thus, funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:
- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	# of LOIs
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff examined 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.

In May 2017, CalOptima received final payment from DHCS for the IGT 6 and 7 transaction and confirmed CalOptima's total share to be approximately $31.1 million.

Discussion

The IGT Ad Hoc committee consisting of Supervisor Do and Directors Nguyen and Schoeffel met on February 17 and reconvened on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Since receiving the RFI/LOIs, the County of Orange over the past several months has been engaged in addressing the homelessness in Orange County. Numerous public agencies and non-profit organizations, including CalOptima, have been working diligently to address this challenging matter. A lot has been accomplished, yet much more needs to be addressed.

Before making recommendation to the Board on the release of the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of up to $10 million to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's members in the priority area of Homeless Health

This will result in a remaining balance of approximately $21.1 million, which the Ad Hoc will consider separately and return to the Board with further recommendations.

In addition, staff is seeking authority to amend the grant agreement with the County to direct the allocation of up to $10 million of funds to provide recuperative care services for homeless CalOptima members under the recuperative care/WPC Pilot. The current agreement with the County allows CalOptima to pay for a maximum of $150 per day up to 15 days of recuperative care per member, with the County responsible for any costs. Staff is proposing to remove the cap on the daily rate and allow the $10 million to be used for funding 50 percent of all medically justified recuperative care days up to

a maximum of 90 days per homeless CalOptima member, to the extent that funds remain available, and subject to negotiation of an amendment to include indemnification by the County in the event that such use of CalOptima IGT funds is subsequently challenged or disallowed.

The WPC Pilot, a county-run program is intended to focus on improving outcomes for participants, developing infrastructure and integrating systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. The current WPC Pilot budget and services are as follows:

		Add'l	
	Total WPC	**County Funds**	**CalOptima**
WPC Connect - electronic data sharing system	$ 2,421,250	$ -	$ -
Hospitals - Homeless Navigators	$ 5,164,000	$ -	$ -
Community Clinics - Homeless Navigators	$ 7,495,000	$ -	$ -
Community Referral Network - social services referral system	$ 1,000,000	$ -	$ -
Recuperative Care Beds	$ 4,277,615	$ 3,483,627	$ 522,100
MSN Nurse - Review & Approval of Recup. Care	$ 628,360	$ -	$ -
211 OC - training and housing coordination	$ 526,600	$ -	$ -
CalOptima - Homeless Personal Care Coordinators & Data Reporting	$ 809,200	$ -	$ -
Housing Navigators	$ 1,824,102	$ -	$ -
Housing Peer Mentors	$ 1,600,000	$ -	$ -
County Behavioral Health Services Outreach Staff	$ 1,668,013	$ -	$ -
Shelters	$ 2,446,580	$ -	$ -
County Admin	$ 1,206,140	$ -	$ -
TOTAL	$31,066,860	$ 3,483,627	$ 522,100

Since the 2016, the OCHCA collaborated with other community-based organizations, community clinics, hospitals, county agencies and CalOptima and others to design the program and has met with stakeholders on a weekly basis. The recuperative care element of the WPC pilot is a critical component of the program. During the first program year, the WPC recuperative care program provided vital services to homeless CalOptima members. CalOptima members in the WPC pilot program are recuperating from various conditions such as cancer, back surgery, and medication assistance and care for frail elderly members. The WPC pilot program has three recuperative care providers providing services, Mom's Retreat, Destiny La Palma Royale and Illumination Foundation.

From July 1, 2017 through June 30, 2018, the WPC pilot program provided the following recuperative care services and linkages for members:

- 445 Homeless CalOptima members admitted into recuperative care for a total of 16,508 bed days
- 22% Homeless CalOptima members served by Illumination Foundation placed into Permanent Supportive Housing
- 4 Homeless CalOptima members in recuperative care approved for Long-Term Care services
- 6 Homeless CalOptima members in recuperative care approved for Assisted Living Waiver services

- Total cost for recuperative care services over the fiscal year: $2,946,700
    - Average length of stay: 37 days
    - Average cost per member: $6,623

The OCHCA experienced a shortfall in the budgeted funds for the WPC/Recuperative Care Program in Year 1 as more individuals were identified to be eligible for the program than projected. The Whole Person Care pilot budget is approximately $31 million, with $8.4 million allocated to provide recuperative care. As the WPC pilot moves into the new fiscal year, the program continues to experience a shortfall. To address the budget shortfall, the number of admissions into the recuperative care program was restricted; however, projected need is projected to increase over the next three years to approximately 2,368 homeless individuals, or 790 per year. The program will need approximately $18.6M over the next three years to meet the increased need for recuperative care services. The County's remaining WPC budget for recuperative care services over this period is approximately $5.3 million.

Individuals who are recovering safely through the program are connected to medical care, including primary care medical homes and medical specialists. In addition, members may receive behavioral health therapy and/or substance use disorder counseling services. Clients from the WPC pilot program are seven times more likely to use the Emergency Room (ER) and nine times more likely to be hospitalized than general Medi-Cal Members.

The WPC recuperative care program serves and is available for homeless CalOptima members when medically indicated, for members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics, and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and IGT 7 to the OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal 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
None

/s/ Michael Schrader — *7/25/2018*
Authorized Signature — **Date**

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

13. Consider Authorization of Expenditure Plan for Intergovernmental Transfer (IGT) 6 and 7 Funds, Including the Release of Requests for Proposals (RFPs) for Community Grants to Address Children's Mental Health, Opioid and Other Substance Overuse, and Other Community Needs Identified by the CalOptima Member Health Needs Assessment

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve the expenditure plan for allocation of IGT 6 and 7 funds in the amount of $21.1 million for the Department of Health Care Services (DHCS)-approved and Board-approved priority areas; and
2. Authorize the release of Requests for Proposal (RFPs) for community grants and internal project applications, with staff returning at a future Board meeting with evaluation of proposals and recommendations for award(s) being granted.

Background

Intergovernmental Transfers are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Health Needs Assessment

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the above referenced priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	**# of LOIs**
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Staff performed an examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

In late May 2018, CalOptima received final IGT 6 and 7 funding from DHCS, resulting in a total of $31.1 million for CalOptima's share of the combined IGT transaction. IGT 6/7 funds totaled $31.1 million rather than the initially projected $22 million due to an adjustment in the enrollment numbers estimated by the California Department of Health Care Services and the higher federal match for the expansion population. On August 2, 2018, CalOptima's Board of Directors approved a $10 million allocation from the Homeless Health priority area to the County of Orange Health Care Agency for the Recuperative Care services under the Whole Person Care pilot program; resulting in a remaining available balance of $21.1 million.

The IGT 6 and 7 Ad Hoc committee comprised of Supervisor Do, and Directors Nguyen and Schoeffel, met on July 20 and July 27 to discuss the results of the 117 RFI/LOI responses for the Children's Mental Health, Opioid and other Substance Overuse as well as to review recommendations for other program areas identified by the Member Health Needs Assessment (MHNA). Following the review of the staff evaluation process and RFP recommendations, the Ad Hoc committee and staff determined allocation amounts and descriptions for each of the proposed six (6) Request for Proposals (RFPs). In addition, staff is recommending an allocation of IGT dollars for internal projects and program administration in the amounts indicated.

The Ad Hoc committee is recommending the following allocation of approximately $17.7 million for IGT 6 and 7 Board-approved priority areas through six (6) RFPs. Please note that multiple applicants may be selected per RFP to receive a grant award.

Community Grants

Request for Proposal	Priority Area	Allocation Amount
Access to Outpatient Mental Health Services	Children's Mental Health	~~$2,700,000~~ $4,850,000
Integrate Mental Health Services into Primary Care Settings	Children's Mental Health	~~$7,000,000~~ $4,850,000
Increase access to Medication-Assisted Treatment (MAT)	Opioid and Other Substance Overuse	$6,000,000

Rev. 9/6/18

Expand Mobile Food Distribution Services	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$500,000
Expand Access to Food Distribution Services focused on Children and Families	Community Needs Identified by the MHNA/Childhood Obesity and Children's Health	$1,000,000
Expand Access to Food Distribution Services for Older Adults	Community Needs Identified by the MHNA/Older Adult Health	$500,000
TOTAL		**$17,700,000**

Rev. 9/6/18

Internal Projects and Program Administration

In addition, staff is also recommending an allocation of approximately $3.4 million for internal projects and IGT program administration to manage all IGT program projects as follows:

Internal Project Examples: - IS and other infrastructure projects	$2,500,000
IGT Program Administration - Support for two (2) existing staff positions for three years - Grant Management System license, and other administrative costs for three years	$949,289 *(Approx. $317,000 per year for three years)*
TOTAL	**$3,449,289**

Staff anticipates returning with recommendations of RFP grantee awards and internal project(s) for Board approval following the completion of the community grant and internal project RFP application processes at the February 2019 Board meeting. The staff positions are Manager, Strategic Development, and Program Assistant, and the above proposed funding is in addition to $10 million allocated from IGT 6/7 for Homeless Health on August 2, 2018.

Fiscal Impact

The recommended action to approve the expenditure plan and allocation of $21.1 million from IGT 6 and 7 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

/s/ Michael Schrader — *8/29/2018*
Authorized Signature — **Date**

Back to Agenda

Back to Item

IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

Back to Agenda

Back to Item

IGT 6 & 7 - Background

Back to Agenda

- Board Established 3 New Priority Areas
  1. **Homeless Health**
  2. **Opioid and Other Substance Overuse**
  3. **Children's Mental Health**
  - ➢ Community needs identified by MHNA
  - ➢ Internal projects and IGT program administration
- Received 117 LOIs
- $10.0M allocated for County HCA for Homeless Health/WPC Recuperative Care
- Ad Hoc met to discuss recommendations for other categories

Back to Item

IGT 6 & 7 Funding

Back to Agenda

- **$31.1M** CalOptima's share
- **$10.0M** to County HCA for WPC Recuperative Care
- **$21.1M** remaining for recommended distribution
  - ➢ $17.7M for Community Grants
    - Six Request for Proposals (RFPs)
      - 2 RFPs in Children's Mental Health
      - 1 RFP in Opioid and other Substance Overuse
      - 3 RFPs for MHNA identified needs
  - ➢ $3.4M for Internal Projects and Program Administration

Back to Item

IGT 6 & 7 LOI Summary

Back to Agenda

Priority Area	# Received
Children's Mental Health	57
Homeless Health	36
Opioid & Other Substance Overuse	22
Other/multiple categories	2
Total	**117**

Back to Item

Children's Mental Health – 2 RFPs

Back to Agenda

RFP #	RFP Description	Funding Amount
1	Expand Access to Outpatient Mental Health Services	$2.7 million
2	Integrate Mental Health Services into Primary Care Settings	$7.0 million
	Total	**$9.7 million**

Back to Item

* Multiple awardees may be selected per RFP

RFP 1

Back to Agenda

Expand Access to Outpatient Children's Mental Health Services

- **Funding Amount:** $2,700,000
- **Description:**
  - Access to outpatient services
    - Create/expand school or resource center-based mental health services for children.
    - Provide services on-site, in-home, and/or afternoon/evening
    - Use an integrated model with community health workers to target vulnerable populations such as children experiencing homelessness, who have experienced traumatic incidences, homeless etc.
    - Provide additional support services to help promote stability and success

Back to Item

RFP 2

Back to Agenda

Integrate Children's Mental Health Services into Primary Care Settings

- **Funding Amount:** $7 million
- **Description:**
  - Integrate mental health services provided in primary care settings
    - Include behavioral health providers in clinics and/or other settings where children are provided health care services
    - Provide culturally sensitive services
    - Provide efficient and immediate access to mental health consultation
    - Provide health navigation/scheduling coordinator to ensure availability and follow-up of services

Back to Item

Opioid & Other Substance Overuse – 1 RFP

Back to Agenda

RFP #	RFP Description	Funding Amount
3	Increase access to Medication-Assisted Treatment	$6.0 million
	Total	**$6.0 million**

Back to Item

*Multiple awardees may be selected per RFP

RFP 3

Back to Agenda

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

- **Description:**
  - Increase access to Medication-Assisted Treatment (MAT) Programs
    - Combine behavioral and physical health services
    - Manage oversight and prescribing of FDA-approved medications and program administration
    - Provide management of patients' overall care coordination
  - Integrate pain management services
  - Ensure availability of providers/staff to deliver appropriate services
  - Establish a partnership with the Orange County Health Care Agency Drug Medi-Cal Organized Delivery System (ODS) for referrals/collaboration

Back to Item

Community Needs Identified by MHNA: Food Access – 3 RFPs

Back to Agenda

RFP #	RFP Description	Funding Amount
4	Expand Mobile Food Distribution Services	$500K
5	Expand Access and Food Distribution focused on Children and Families	$1 million
6	Expand Access to Older Adults Meal Programs	$500K
	Total	**$2 million**

Back to Item

*Multiple awardees may be selected per RFP

RFP 4

Back to Agenda

Expand Mobile Food Distribution Services

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase availability and access to healthy food options in areas of where fresh food/grocery stores are limited
  - Ensure additional mobile food trucks/vehicles to distribute healthy food options such as fresh produce/groceries that are culturally appropriate in areas of greatest need
  - Enroll members in mobile food distribution services programs
  - Provide education to prepare nutritious meals and/or pre-made meal options and simple recipes

Back to Item

RFP 5

Back to Agenda

Expand Access and Food Distribution Services focused on Children and Families

- **Funding Amount:** $1 million
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Access to healthy food options such as fresh fruits, vegetables and other groceries
  - Increase access to culturally appropriate food options
  - Enroll/connect members to food distribution service programs
  - Provide education and simple recipes to help families on a limited budget
  - Provide take-home meals for children/families who may not have access to cooking facilities

Back to Item

RFP 6

Back to Agenda

Expand Access to Older Adult Meal Programs

- **Funding Amount:** $500,000
- **Description:**
  - MHNA data shows more than 30% of members indicated they needed help obtaining food each month
  - Increase access to:
    - Healthy options such as fresh fruits, vegetables and other groceries in areas of highest need
    - Culturally appropriate food options
    - Home delivered meals
  - Enroll/connect member food distribution service programs

Back to Item

Internal Projects/Program Admin.

Back to Agenda

Description	Amount
IS and Other Infrastructure Projects	$2.5 million
Support for staff and administrative costs	~$315K/year (for 3 years)

Back to Item

Next Steps*

Back to Agenda

- IGT 6 & 7 RFP Recommendations: September 6, 2018 Board Meeting
- Release of RFPs: September 2018
- RFPs due: November 2018
- IGT Ad Hoc review of recommended grant awards: January 2019
- Recommended awards: February 2019 Board Meeting

Back to Item

* Dates are subject to change based on Board approval

Back to Agenda

Back to Item

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors
February 22, 2019

Michael Schrader
Chief Executive Officer

Agenda

Back to Agenda

- Current system of care
- Strengthened system of care
- Federal and State guidance
- Activities in other counties
- Considerations
- Recommended actions

Back to Item

Current System of Care

Back to Agenda

Key Roles	Agency
Public Health	County
Physical Health	CalOptima*
Mental Health – mild to moderate	CalOptima*
Serious Mental Illness (SMI) and Substance Use Disorder	County
Shelters	County and Cities
Housing supportive services for SMI population • Housing search support • Facilitation of housing application and/or lease • Move-in assistance • Tenancy sustainment/wellness checks	County
Intensive Care Management Services	County and CalOptima*
Medi-Cal Eligibility Determination and Enrollment	County
Presumptive Medi-Cal Eligibility	State Medi-Cal Fee-for-Service Program

**For Medi-Cal Members*

Back to Item

Current System of Care (Cont.)

Back to Agenda

- Services available to Medi-Cal members through CalOptima
  - Physician services – primary and specialty care
  - Hospital services and tertiary care
  - Palliative care and hospice
  - Pharmacy
  - Behavioral health (mild to moderate)

Back to Item

- Recuperative care funding with IGT dollars through County's Whole-Person Care Pilot
  - A clean and safe place for homeless individuals to recover from illness or injury for up to 90 days
  - A form of short-term shelter based on medical necessity

Gaps in the Current System of Care

Back to Agenda

- Access issues for homeless individuals
  - Difficulty with scheduled appointments
  - Challenges with transportation to medical services
- Coordination of physical health, mental health, substance use disorder treatment, and housing
- Physical health for non-CalOptima members who are homeless
  - Individuals may qualify for Medi-Cal but are not enrolled

Back to Item

Immediate Response

Back to Agenda

- In 2018, more than 200 reported homeless deaths in Orange County
  - Roughly double the number of homeless deaths in San Diego County
- CalOptima Board
  - On February 20, 2019, Quality Assurance Committee tasked staff to investigate
    - Percentage that were CalOptima members
    - Demographics
    - Causes of death
    - Prior access to medical care
  - Identify opportunities for improvement

Back to Item

Strengthened System of Care

Back to Agenda

- Vision
  - Deliver physical health care services to homeless individuals where they are
- Partner with FQHCs to deploy mobile clinical field teams
  - Reasons for partnering with FQHCs
    - Receive CalOptima reimbursement for Medi-Cal members
    - Receive federal funding for uninsured
    - Enrollment assistance into Medi-Cal
    - Offer members education on choosing FQHC as their PCP
  - About the FQHC clinical field teams (a.k.a., “Street Medicine”)
    - Small teams (e.g., physician/NP/PA, medical assistants, social worker)
    - Available with extended hours
    - Go to parks, riverbeds and shelters
    - In coordination with County Outreach and Engagement Team (a.k.a., “Blue Shirts”)

Back to Item

Federal and State Guidance

Back to Agenda

- Depending on the state-specific waivers and county contracts with state, Medicaid funds can be used for coverage of certain housing-related activities, such as
  - ➢ Intensive case management services
    - Section 1915(c) Home and Community Based Services waiver
      - e.g., In-Home Supportive Services and Multipurpose Senior Services Program
  - ➢ Housing navigation and supports
    - Section 1115 waiver
      - e.g., Whole-Person Care Pilot

Back to Item

Federal and State Guidance (Cont.)

Back to Agenda

- Medicaid funds cannot be used for rent or room and board
  - CMS Informational Bulletin – June 26, 2015
- CalOptima's Medi-Cal revenue and reserves can be used for the CalOptima Medi-Cal program only
  - Welfare & Institutions Code section 14087.54 (CalOptima enabling statute)

Back to Item

Activities in Other Counties

Back to Agenda

- Los Angeles County
  - LA County administers a flexible housing subsidy pool
  - L.A. Care provided a $4 million grant (total commitment of $20 million over 5 years) for rent subsidies to house 300 individuals
    - L.A. Care has other sources of revenue beyond Medi-Cal (e.g., Covered California commercial plan)
- Riverside and San Bernardino Counties
  - Inland Empire Health Plan contributes to a housing pool to provide housing supportive services for 350 members
- Orange County
  - Housing pool not in existence today under WPC Pilot
  - If established pursuant to the 1115 Waiver (e.g., under WPC), CalOptima could contribute funds for housing supportive services, not rent

Back to Item

Considerations

Back to Agenda

- Establish CalOptima Homeless Response Team
  - Dedicated CalOptima resources
  - Coordinate with clinical field teams
  - Interact with Blue Shirts, health networks, providers, etc.
  - Work in the community
  - Provide access on call during extended hours
- Fund start-up costs for clinical care provided to CalOptima members
  - On-site in shelters
  - On the streets through clinical field teams

Back to Item

Additional Considerations

Back to Agenda

- Look at opportunities to support CalOptima members who are homeless
  - ➢ Contribute to a housing pool
    - Housing pool must exist under an 1115 waiver program (e.g. WPC) in order to use Medi-Cal funds
    - CalOptima contribution used towards housing navigation and support services; cannot be used towards rent or room and board

Back to Item

Recommended Actions

Back to Agenda

- Authorize establishment of a clinical field team pilot program
  - Contract with any willing FQHC that meets qualifications
  - ~~CalOptima financially responsible for services regardless of health network eligibility~~
  - ~~One year pilot program~~
  - ~~Fee-for-service reimbursement based on CalOptima Medi-Cal fee schedule~~

Back to Item

- Authorize reallocation of up to $1.6 million from IGT 1 and 6/7 to fund start-up costs for clinical field team pilot
  - ~~Vehicle, equipment and supplies~~
  - ~~Staffing~~

Recommended Actions (Cont.)

Back to Agenda

- Authorize establishment of the CalOptima Homeless Response Team
  - Authorize eight unbudgeted FTE positions and related costs in an amount not to exceed $1.2 million
- Return to the Board with a ratification request for further implementing details
- Consider other options to work with the County on a System of Care
- Obtain legal opinion related to using Medi-Cal funding for housing-related activities

Back to Item

CalOptima's Mission

Back to Agenda

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

Back to Item

Back to Agenda

Back to Item

Back to Agenda

Back to Item

RFP 1. Expand Access to Outpatient Children's Mental Health Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Access California Services	$ 195,000	Playing with Rainbows	Provide an innovative play-based therapeutic program that facilitates the process of healing in immigrant and/or refugee children who have been traumatized by war and migration through the use of a group counseling process involving play and art.
Boys & Girls Club of Anaheim Inc.	$ 1,331,418	Wild at Heart	A therapeutic wilderness program focused on improving children's mental health, coping skills and resilience through evidence-based outdoor experiential therapy to at-risk youth aged 12 to 18
Boys & Girls Clubs of Garden Grove	$ 325,200	Teen Mental Health Leadership Program	Reduce stigma, increase coping skills, and triage mental health care by providing peer training to community-based teen empowerment programs and education around outreach and stigma reduction.
Casa de la Familia (CDLF)	$ 1,840,968	SAUSD Mental Health Project	Provide culturally sensitive counseling, case management, outreach and parental support services to students and parents within the Santa Ana Unified School District.
Child Guidance Center, Inc	$ 1,207,053	School Based Behavioral Health Services for Military/Veteran Connected Families	Expand resource center-based behavioral health services for veteran and military connected children by providing early intervention, prevention programs and behavioral health services to children in a community-based setting. Program will also provide training to schools and implement peer navigators. Program will leverage MHSA Innovation project with the Family Resource Centers.

Back to Agenda Back to Item

Organization Name	Request ($)	Project Title	Project Description
Children's Bureau of Southern California (Children's Bureau)	$ 3,500,000	Children's Mental Health Access Collaborative	Bring together 12 outpatient mental health services providers to expand access to mental health services and increase coordination, outreach, peer support, and systems integration. Providing other Early Childhood Mental Health interventions not currently covered by MHSA funds or Medi-Cal.
CSU Fullerton Auxiliary Services Corporation	$ 4,033,395	The Early Childhood Mental Health and Wellness Program	Implement a Early Childhood Mental Health and Wellness Program through a facilitated process by a consultant and a leadership team of early care and education programs.
Gay and Lesbian Community Services Center of Orange County	$ 120,000	LGBT Center OC's Mental Health Program for Children and Youth	Provide CalOptima members ages 4-18 years with individual and family therapy as appropriate; mental health support groups for children and youth; drop-in counseling sessions for foster children; and; community groups focused on mental and emotional wellness
Hurtt Family Health Clinic	$ 745,812	Family Counseling Services for Homeless, Poor and Foster Children and Youth	Provide family counseling services to homeless families residing in Orange County Rescue Mission's transitional housing programs.
Illumination Foundation	$ 1,080,384	Children and Family In-Home Stabilization Program	Bring in-home services and individualized counseling to more families with children who are at risk of developing emotional and behavioral disorders.
Jamboree Housing Corporation	$ 692,000	Children's Behavioral Health Peer Navigation Collaboration	Pilot program to provide accessible behavioral health services for children and their families living at Jamboree's Clark Commons and surrounding Buena Park communities through an afterschool program, resident leadership training, food and nutrition workshops, and computer classes. The program will use an evidence-based peer navigation model (peer with lived experience), as well as connect members to clinical care.

Organization Name	Request ($)	Project Title	Project Description
Latino Center for Prevention & Action in Health & Welfare DBA Latino Health Access for Children with Adverse Childhood Experiences	$ 450,000	Promotora/ Community Health Worker-Facilitated Emotional Wellness and Mental Health Services	Prevention and intervention mental health program for Latino children who have had Adverse Childhood Experiences (ACE) that have resulted in trauma.
Living Success Center, Inc.	$ 1,351,000	Outreach and Education Expansion of Children's Mental Health Services	A 3-year outreach and education project to identify those in need, targeting homeless shelters and domestic violence service providers to help and counsel children who have experienced trauma .
Mariposa Women and Family Center	$ 238,898	Mariposa Children's Intervention Program (CHIP)	Use existing partnerships with local school districts, local community institutions, and low-income parents to provide programming to engage children and identify and treat mental health issues among children in Orange County.
NAMI Orange County	$ 546,380	Mental Health Education & Outreach	Offer evidence based programs such as Parent Connector, Basics Education, Progression, NAMI Connects at CHOC, and a quarterly Family Fun Event - 1K Awareness Walks for Families in collaboration with Family Resource Centers (FRC).
OC United	$ 901,500	Creating Capacity and Expanding Resilience for Children, Families, and their Communities	Expand current program engagement in local organizations, pilot a Whole-Child Treatment Team model, increase community resilience and engagement, reduce stigma, as well as increase accessibility to resources.
OCAPICA (Orange County Asian & Pacific Islander Community Alliance, Inc)	$ 685,000	The API Project HOPE	Provide mental health and wellness, culturally competent and linguistically appropriate services that include outreach and education to promote health awareness, support groups, educational trainings, resource referral and linkage, etc. Program will provide case management, in-home/community-based group counseling.

Organization Name	Request ($)	Project Title	Project Description
Orange County Department of Education	$ 4,583,290	School-Based Student Wellness Centers	Pilot School-Based Student Wellness Centers (SWCs) within seven Orange County districts where all students can access support, resources and information on a variety of topics around mental health at their school site.
PADRES UNIDOS	$ 55,000	Early Learning Programs	Provide community-based modules such as Parents as Teachers/Early Education Modules where parents have identified that preschool-aged kids exhibit early signs of concerning behavior that can lead to future mental health challenges.
Radiant Health Centers	$ 450,000	Children's Mental Health Program Expansion	Provide outreach, community partnership building and outpatient mental health services with a focus on the subpopulations of children infected or affected by HIV and LGBTQ+ youth. The program will reduce stigma, increase awareness of mental health services and increase access to services.
Straight Talk Clinic, Inc.	$ 186,000	Children's Mental Health Support	Expand program with a pilot weekly on-site counseling services and comprehensive outreach series for children and families.
The Center for Autism & Neurodevelopmental Disorders	$ 743,672	Child Mental Health Cooperative (CMHC)	Expand child mental health services by delivering a consultative support program to providers, creating a unique interactive video-conferencing classroom and optimizing partnerships and collaborations.

Organization Name	Request ($)	Project Title	Project Description
Vision y Compromiso	$ 875,235	Salud y Bienestar Para Todos	Collaborate with schools and community partners in Anaheim and Westminster to deliver evidence-based outreach and education strategies by engaging *promotores* to share information and resources.
Vista Community Clinic	$ 433,045	Providing School-Based Mental Health Services to La Habra Youth in Need	Project will designate 3-5 schools in La Habra as interim FQHC sites and assign three Licensed Clinical Social Workers to provide on-campus, 1-on-1 therapy to youth with mild to moderate behavioral health symptoms.
Wellness & Prevention Center	$ 153,951	Expansion of School and Community-based Youth Wellness Programming	Increase bilingual staff, support a coalition of Spanish-speaking parents and providers, and establish a presence at five new schools and community centers.
Women's Transitional Living Center, Inc.	$ 50,000	Children's Therapy Program	Counselors work with children through treatment plans that are age-appropriate, creative, and flexible, and can incorporate a range of counseling services, including individual counseling, family counseling, art therapy, sand therapy, and play therapy.

RFP 2. Integrate Children's Mental Health Services Into Primary Care			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
AltaMed Health Services Corporation	$ 998,040	Integrating Children's Mental Health Into Primary Care in Orange County	Enhance current pediatric primary care services by integrating mental health services for children, providing referrals to early intervention, and engaging parents through community outreach and education.
CHOC Children's	$ 4,785,076	Expanding Mental Health Access and Knowledge in Pediatric Primary Care and Community Settings	Establish mental health screening, embedded mental health services, telehealth, and resource and referral for members in clinics served by CHOC Medical Group and in CHOC's Primary Care Network. Program will also provide trainings over the 3 years.
Families Together of Orange County	$ 920,000	Expanding Children's Mental Health Services	Integrate children's mental health services into primary care by offering on-site outpatient pediatric mental health care at the community health center in Tustin with outreach and education.
Friends of Family Health Center	$ 600,000	Healthy Steps	Introduce the evidence-based model HealthySteps program designed to have a specialist screen and provide families with support for common and complex concerns during a well-child visit. The HealthySteps specialist will assist with referrals and connects to additional services.
Laguna Beach Community Clinic	$ 69,109	Pediatric Mental Health: Screening and Case Management to Increase Access to Treatment	Provide screening, case management, and linkage to mental health resources and treatment for Cal-Optima members
Livingstone Community Development Corporation	$ 626,000	Integrating Children's Mental Health Services into Medical Care	Integrate outpatient mental health services into pediatric primary care screening and expand its arts and music therapy program.
Share Our Selves Corporation (SOS)	$ 200,000	Children's Mental Health Expansion Project	Expand SOS Children and Family Health Center's hours of operation from 40 to 45 hours per week and access to behavioral health outreach education and counseling services.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 2,848,235	Child Psychiatry Consultation and Fellowship Program for Primary Care Providers (CPCFP)	Provide same day telephone consultation to PCPs by a child and adolescent psychiatrist in addition to rapid tele-video consult with ongoing education and training in mental health.
The Safety Net Foundation (FQHC Collaborative)	$ 2,496,000	Pediatric Integration of Behavioral Health in Primary Care for CalOptima's Safety Net: Expansion of Care Coordination, Mid-Level Provider Availability, Telehealth Options and Evidence-Based Training at Community Health Centers	Increase access to pediatric mental health care through the expansion of mid-level providers, the exploration of telemedicine and the integration of behavioral health with pediatric primary care.
Vista Community Clinic	$ 426,422	Enhancing Children's Mental Health via Primary Care Integration and Community Outreach in La Habra	A primary care - mental health integration project for Hispanic youth and their families living in and around the City of La Habra.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

RFP 3. Increase Access to Medication-Assisted Treatment			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Ahura Healthcare	$ 2,850,000	Medicated-Assisted Treatment (MAT)	Provide comprehensive mental health and addiction medicine care with the use of Medicated-Assisted Treatment (MAT) therapy such as Suboxone, Methadone, and Naltrexone provided by licensed physicians along with mental health services and counseling.
Bright Heart Health	$ 3,915,000	Opioid Use Disorder OnDemand Treatment	Provide complete telehealth MAT services through Data2000 physicians, nurse practitioners, and physician assistants.
Central City Community Health Center	$ 930,000	CCCHC SUD-MAT Services & Educational Program	Expand access to and enhance existing, integrated and evidenced-based, SUD-MAT clinical care program with the City of Anaheim Health Center as the "hub" with services available via in-person provider or telehealth. The project includes providing service through mobile units.
Clean Path Recovery LLC	$ 5,998,484	Clean Path Recovery MAT Program	Program will use FDA approved medications in combination with counseling, holistic and behavioral therapies.

IGT 6/7 Requests for Proposal (26 RFPs)
1. Expand Access to Outpatient Children's Mental Health Services

Organization Name	Request ($)	Project Title	Project Description
Coalition of Orange County Community Health Centers	$ 5,998,000	MATCONNECT: A County-wide Collaborative for MAT Expansion to CalOptima Members at Community Health Centers	Build capacity and expand access and delivery of MAT services by bridging integration gaps in the Substance Use Disorder (SUD) system of care in Orange County. Implement a localized version of the DHCS Hub and Spoke model and build internal capacity for increased MAT services and access for each of the Spoke locations.
Friends of Family Health Center	$ 600,000	Medication Assisted Treatment	Introduce Medication Assisted Treatment (MAT) with emphasis on opioid addiction with an individually tailored and extensive care coordination for patients
Livingstone Community Development Corporation	$ 808,000	Establishing a Substance Abuse Program with Medication-Assisted Treatment	Establish a new medication-assisted treatment (MAT) program which will be integrated with physical and behavioral health services and include supervised exercise and acupuncture treatments.
Serve the People	$ 1,485,000	Integrated Behavioral Health for Hard To Reach Populations	Purchase and staff Integrated Services (IS) Mobile Clinics and provide integrated whole-person care to individuals at the Courtyard and to others in addiction treatment facilities.
Share Our Selves Corporation (SOS)	$ 200,000	SOS Behavioral Health Expansion Project	Increase capacity to provide comprehensive behavioral health and case management services via telehealth technology and new medical/behavioral health mobile unit at homeless shelters operated by SOS's partner agencies throughout the county.

Organization Name	Request ($)	Project Title	Project Description
The Regents of the University of California, Irvine Campus	$ 1,825,518	Establishing and Increasing the capacity of a Medication Assisted Treatment program through a Hub-and-Spoke model for CalOptima patients	Establish and expand the capacity of medication-assisted treatment (MAT) within Orange County. The hubs will be the Zephyr Medical Group in Laguna Hills and UC Irvine Medical Center.

RFP 4. Expand Mobile Food Distribution Services			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 250,000	OC Food Bank Mobile Food Trolley	Project will use OC Food Bank's mobile food trolley to provide a variety of food that is distributed on a first-come, first-served basis and may include items such as produce, non-perishable goods and protein.

RFP 5. Expand Access to Food Distribution Services Focused on Children and Families			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Global Operations & Development / Giving Children Hope	$ 50,000	We've Got Your Back (WGYB)	Food distribution program fills and distributes more than 1,100 backpacks of nutritious food including fruits and vegetables on a weekly basis.
LiveHealthy OC	$ 990,000	The LiveHeathy OC "Farmacy" Project - Establishing a Sustainable Farm to Clinic Network to Increase Access to Fresh, Healthy Foods for Underserved and Low Income Patients	Expands current access to fresh fruits and vegetables using a sustainable farm-to-clinic produce delivery system – the "farmacy" – at five community health centers through a monthly mobile farmers' market.
Livingstone Community Development Corporation	$ 300,000	Expanding Food Access for Children and Families	Expanding food pantry and integrate access to the food pantry into Group Medical Visits with CalOptima members suffering from diabetes, obesity, hypertension, and/or heart disease
Serve the People	$ 1,000,000	OC Food Oasis Partnership	Expand mobile food distribution to five FQHC sites and shelters that serve homeless persons. The strategy is to include healthy food and meal distribution, nutrition education, a 'food as medicine' prescription food box program for patients with chronic disease, and demonstrations on healthy food preparation and cooking, plus outreach and case management to services establishing a system to address social determinants of health.

Organization Name	Request ($)	Project Title	Project Description
Vista Community Clinic	$ 289,533	In the Kitchen: An Innovative Education/Food Distribution Program in La Habra	Develop a teaching kitchen that will provide nutrition education and hands-on cooking lessons to participants (accommodate groups of 12 residents).

RFP 6. Expand Access to Food Distribution Services for Older Adults			
Organization Name	**Request ($)**	**Project Title**	**Project Description**
Community Action Partnership of Orange County	$ 231,514	Farm-to Seniors Food Distribution Program	Provide fresh, healthy food to older adult CalOptima members through a network of 17 distribution sites.
Multi-Ethnic Collaborative of Community Agencies	$ 500,000	Increasing Food Access for Underserved Multi-Ethnic Older Adults	Expand food access distribution at the seven MECCA sites by building the volunteer base capacity, expand outreach, and provide culturally appropriate education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Allocation of Intergovernmental Transfer 5 Funds

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

Rev. 8/1/19

1. Approve the amended recommended allocations of IGT 5 funds in the total amount of $2.4 million ~~3.4 million~~ for RFP 2., Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics) and RFP 3., Adult Dental Services for community grants; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute grant contracts with the recommended community grantees.
3. The Board directed staff to bring back details of applications submitted for Request for Proposal (RFP) Category 1., Access to Children's Dental Services for a funding amount of $1 Million, including criteria, evaluations, scoring sheets, and qualifications for further review at its September 5, 2019, Board of Directors meeting.

Background

Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1-7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net.

On December 1, 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) the results of which would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per the approved priority areas. The MHNA data collection activities were completed in November 2017.

Back to Agenda Back to Item

On February 1, 2018, a summary of MHNA results was shared with the CalOptima Board of Directors. Based on the results of the MHNA, the Board additionally approved the release of eight RFPs for $14.4 million community grants in the following categories:

- 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

In preparation for the release of the RFPs, staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. On June 7, 2018, the CalOptima Board approved release of Requests for Information related to these eight categories; ninety-three responses in July 2018.

On December 6, 2018, the CalOptima Board of Directors approved $11.4 million of IGT 5 funds to the Be Well Wellness Hub in December 2018. At that time, the Board of Directors also approved the release of the three following RFPs in the total amount of $3.4 million ($3 million remaining in IGT 5 and $400,000 reallocated from IGT 2) for community grants.

Request for Proposal	Priority Area	Allocation Amount
1. Access to Children's Dental Services	Strengthening the Safety Net	$1.0 million
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Strengthening the Safety Net	$1.4 million
3. Adult Dental Services	Strengthening the Safety Net	$1.0 million

The three RFPs garnered 20 responses. External subject matter experts and 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 IGT 5 Ad Hoc committee comprised of Dr. Nikan Khatibi and Dr. Alexander Nguyen met on July 23, 2019 to discuss the results of the 20 RFP responses for Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Adult Dental Services. Following the review of the evaluation committee results, the Ad Hoc committee is recommending the following allocation of $3.4 million for IGT 5 board-approved priority areas through three (3) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Access to Children's Dental Services	Healthy Smiles for Kids of Orange County	$1,000,000
RFP 2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Santa Ana Unified School District	$1,400,000
RFP 3 Adult Dental Services	KCS Health Center (Korean Community Services)	$1,000,000

Fiscal Impact

The recommended action to approve the allocation of $3.4 million from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT 5 Expenditure Plan Allocation
2. CalOptima Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants
3. CalOptima Board Action dated June 7, 2018, Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)
4. CalOptima Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Intergovernmental Transfer (IGT) 5 Funds
5. CalOptima Board Action dated December 6, 2018, 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.
6. List of responders by RFP category.

_____ _____

Authorized Signature **Date**

Back to Agenda

Back to Item

IGT 5 Community Grant Award Consideration

Board of Directors Meeting

August 1 2019

Candice Gomez

Executive Director, Program Implementation

Back to Agenda

Back to Item

Background

Back to Agenda

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population

Back to Item

- CalOptima Board of Directors approved IGT 5 priority areas for community-based funding opportunities
  - Childhood Obesity
  - Mental Health (Adult and Children's)
  - Improving Children's Health
  - Strengthening the Safety Net

IGT 5 Background Summary

Back to Agenda

Board authorized Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identified categories for community grants

Board authorized Requests for Information (RFIs) to better define the scopes of work in each of the categories

Back to Item

93 RFI responses lead to the identification possible Requests for Proposal (RFPs)

Board authorized the release of 3 RFPs

RFP Evaluation Criteria

Back to Agenda

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Back to Item

Site Visits

Back to Agenda

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

Back to Item

RFP Summary

Back to Agenda

RFP	Total Received	Total Recommended
1. Access to Children's Dental Service ($1.0 million)	5	1
2. Primary Care Services & Social Determinants of Health ($1.4 million)	6	1
3. Access to Adult Dental Service ($1.0 million)	9	1
Total	**20**	**3**

Back to Item

1. Access to Children's Dental Service ($1 million)

Back to Agenda

Organization	Original Request	Recommended Funding Amount
Healthy Smiles for Kids of Orange County	$1,000,000	$1,000,000
Total	**$1,000,000**	**$1,000,000**

Back to Item

2. Primary Care Services & Social Determinants of Health ($1.4 million)

Back to Agenda

Organization	Original Request	Recommended Funding Amount
Santa Ana Unified School District	$1,400,000	$1,400,000
Total Awarded	**$1,400,000**	**$1,400,000**

Back to Item

3. Access to Adult Dental Service ($1.0 million)

Back to Agenda

Organization	Original Request	Recommended Funding Amount
KCS Health Center (Korean Community Services)	$987,600	$1,000,000
Total	**$987,600**	**$1,000,000**

Back to Item

Recommended Board Actions

Back to Agenda

- Approve the recommended allocations of IGT 5 funds in the amount of $3.4 million for community grants; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

Back to Item

CalOptima's Mission

Back to Agenda

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

Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal 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. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

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

1/25/2018 — **Date**

Back to Agenda

Back to Item

Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

Back to Item

Back to Agenda

Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

Back to Item

Back to Agenda

Back to Item

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Back to Agenda

Back to Item

A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

Back to Agenda

Back to Item

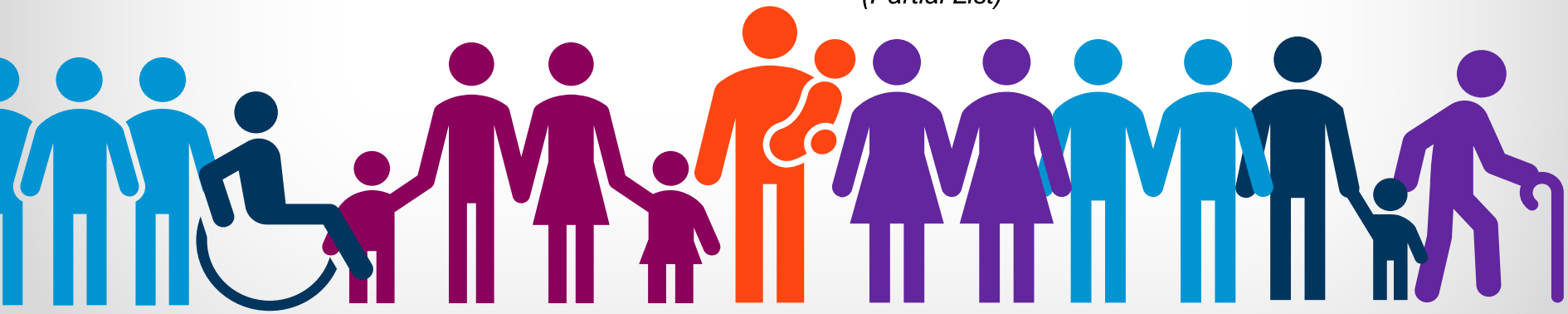
More Comprehensive

Back to Agenda

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)

Back to Item



Back to Agenda

Back to Item

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More Comprehensive (Cont.)

Back to Agenda

- Gathered responses from all geographic areas of Orange County

Back to Item

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More Comprehensive (Cont.)

Back to Agenda

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

Back to Item

Back to Agenda

Back to Item

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More Comprehensive (Cont.)

Back to Agenda

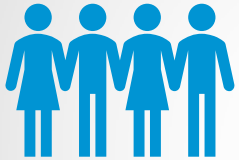
- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

Back to Item

More Engaging: Members

Back to Agenda



Focus Groups

- 31 face-to-face meetings in the community
- 353 members

Telephone Conversations

- 534 live interviews in members' languages

Back to Item

Mailed Surveys

- Nearly 6,000 surveys returned

Electronic Responses

- More than 250 replied conveniently online

Back to Agenda

Back to Item

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More Engaging: Member Advocates

Back to Agenda

Back to Item

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List*)

Back to Agenda

Back to Item

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More Personal

Back to Agenda

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms

Back to Item

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More Personal (Cont.)

Back to Agenda

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

Back to Item

Back to Agenda

Offering Deeper Insight

- → Barriers to Care
- → Lack of Awareness About Benefits and Resources
- → Negative Social and Environmental Impacts

Back to Item

Back to Agenda

Back to Item

Notable Barriers to Care

Back to Agenda

- Study revealed that members encounter structural and personal barriers to care
  - ➢Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - ➢Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

Back to Item

Barriers to Care (Cont.)

Back to Agenda

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

Back to Item

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

Back to Agenda

Back to Item

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Notable Lack of Awareness

Back to Agenda

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

Back to Item

Lack of Awareness (Cont.)

Back to Agenda

Examples

40%

Didn't know who to ask for help with mental health needs

41%

Didn't see a dentist because of cost (i.e., didn't know dental care was covered)

Back to Item

25%

Don't have or know of a dentist

Back to Agenda

Back to Item

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Negative Social and Environmental Impacts

Back to Agenda

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

Back to Item

Negative Impacts (Cont.)

Back to Agenda

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

Back to Item

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

Back to Agenda

Back to Item

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

Back to Agenda

Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

Back to Item

Back to Agenda

Back to Item

Funding

Back to Agenda

$14.4 Million

Total Available IGT 5 Funds

Back to Item

- ➔ **Member Health Needs Assessment results drive funding allocations**

- ➔ **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

Back to Agenda

Back to Item

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Back to Agenda

RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Back to Item

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

Back to Agenda

Back to Item

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Back to Agenda

RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Back to Item

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category

Adult Mental Health

Back to Agenda

Back to Item

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Back to Agenda

RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Back to Item

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category

Children's Mental Health

Back to Agenda

Back to Item

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Back to Agenda

RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Back to Item

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category

Childhood Obesity

Back to Agenda

Back to Item

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Back to Agenda

RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

Back to Item

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

Back to Agenda

Back to Item

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Back to Agenda

RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Back to Item

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category

Supporting the Safety Net

Back to Agenda

Back to Item

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Back to Agenda

RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Back to Item

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category

Supporting the Safety Net

Back to Agenda

Back to Item

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Back to Agenda

RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Back to Item

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category

Children's Health

Back to Agenda

Back to Item

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Moving Forward

Back to Agenda

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

Back to Item

EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

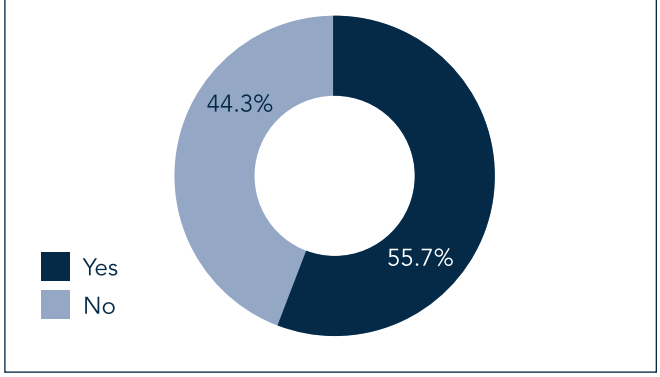
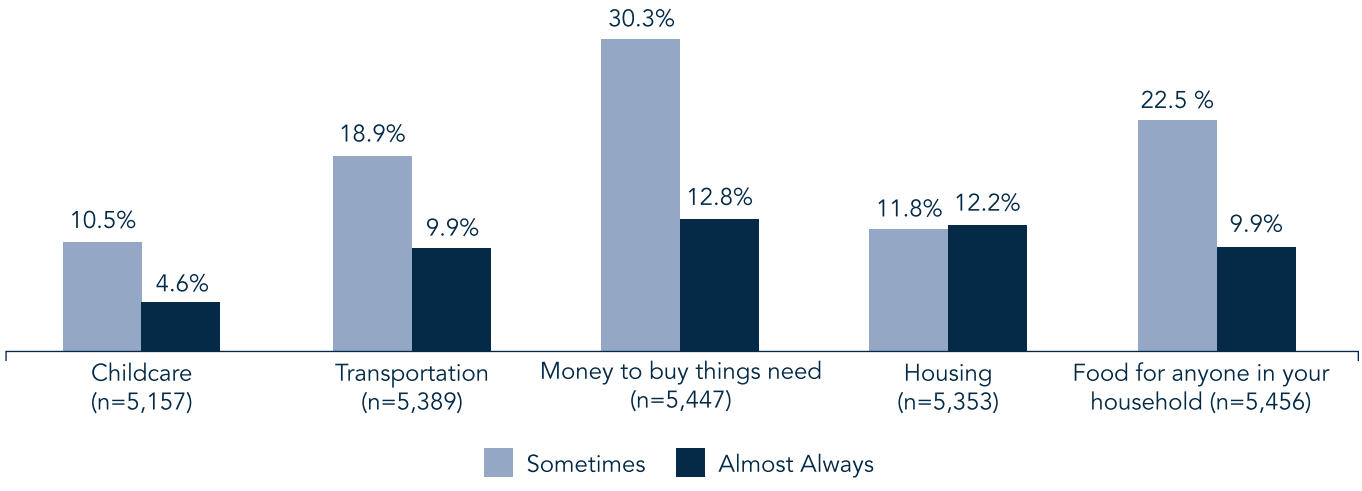
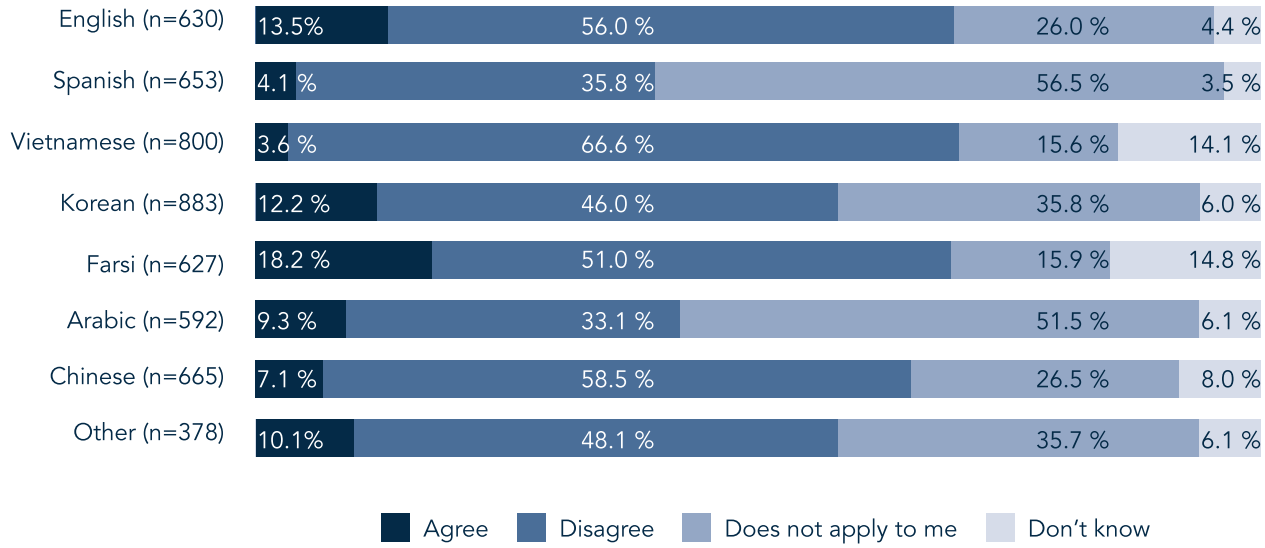


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

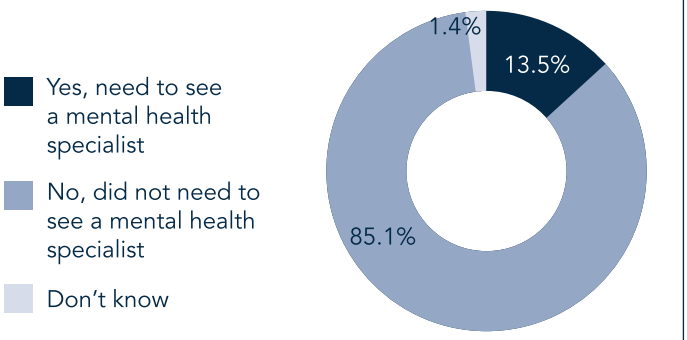
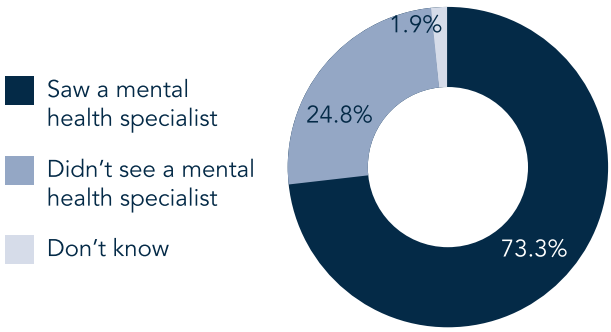
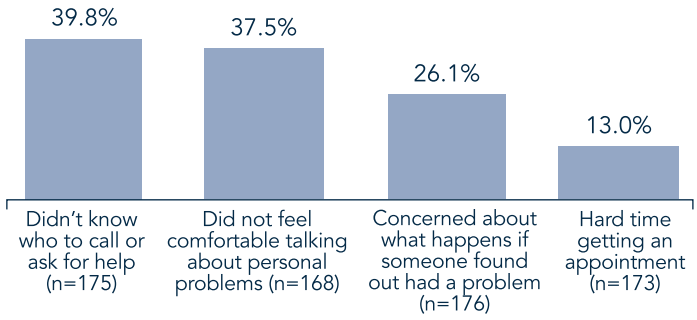


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

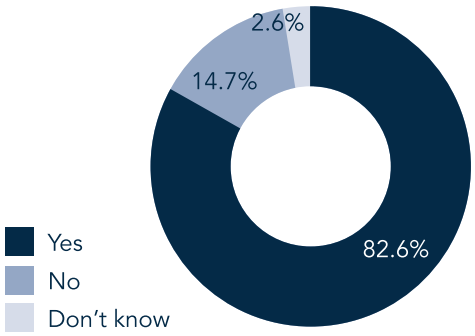
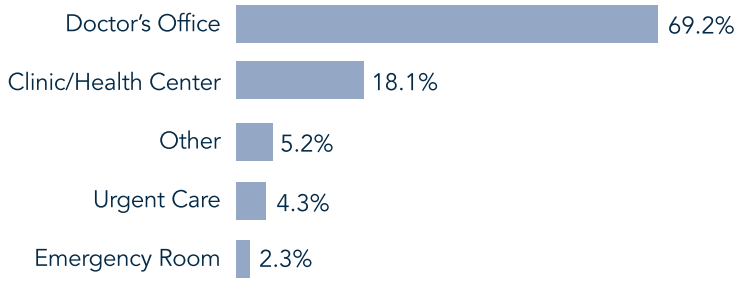


Exhibit 9: Where respondents go to see their doctor (n=5,743)

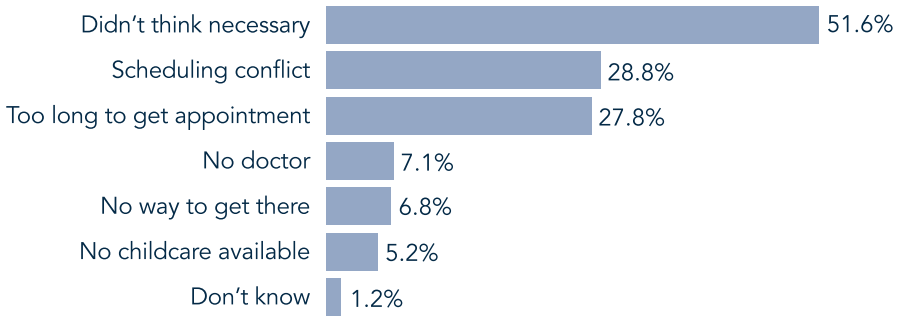


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

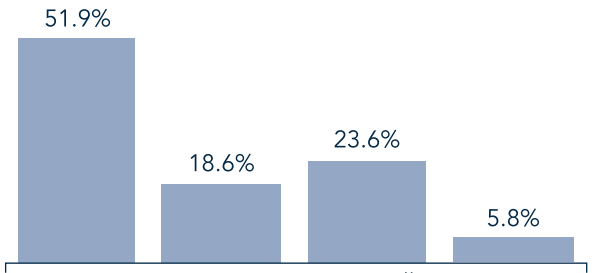
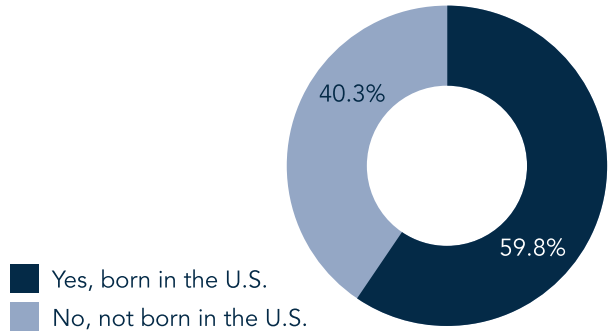


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

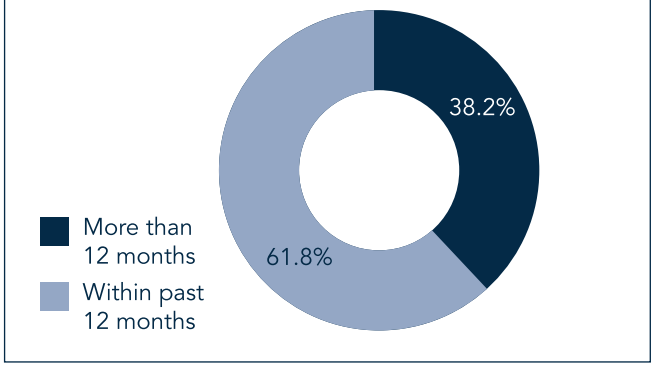
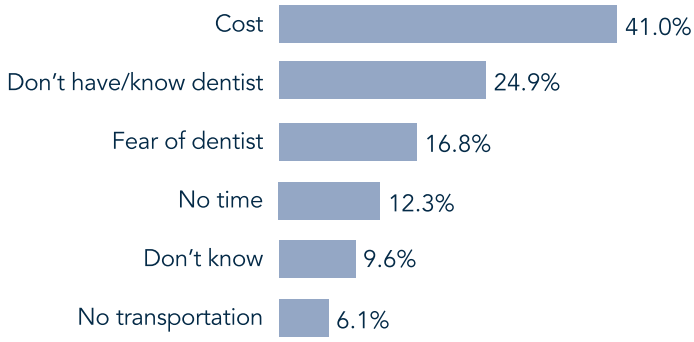


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

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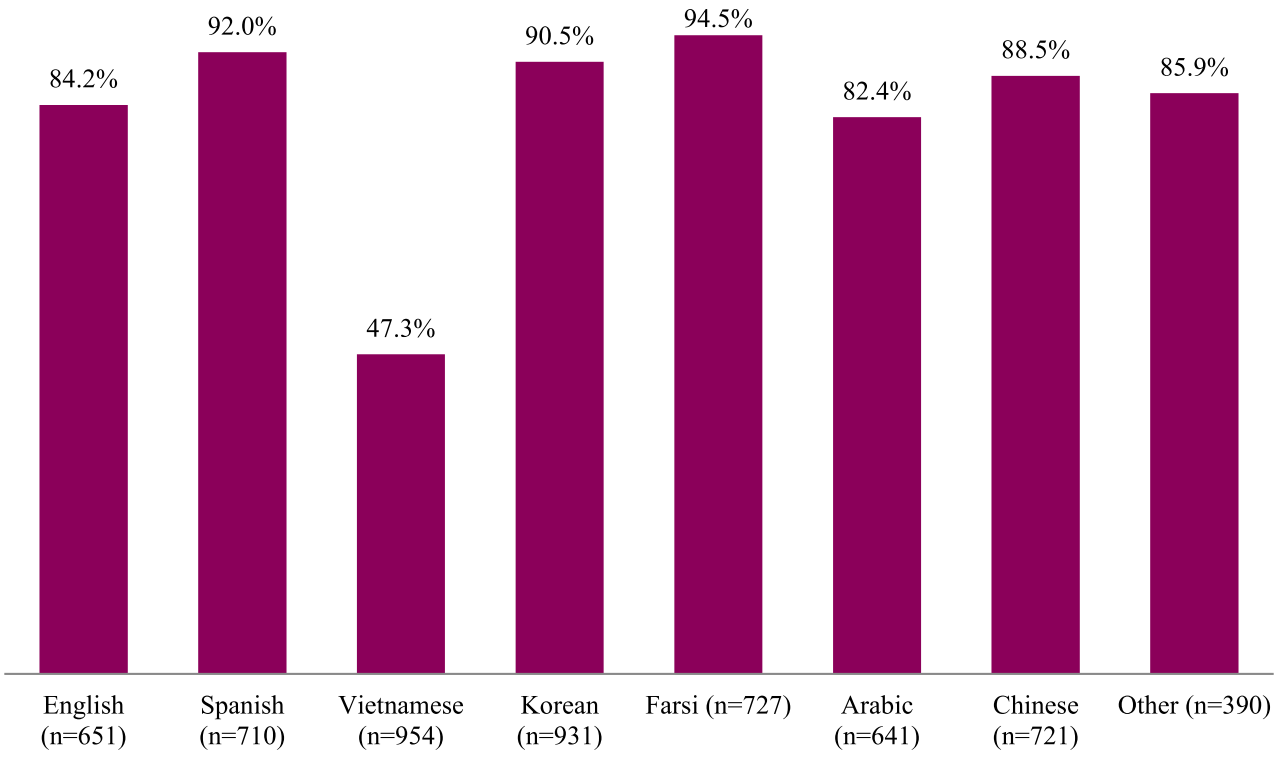
Back to Agenda Back to Item

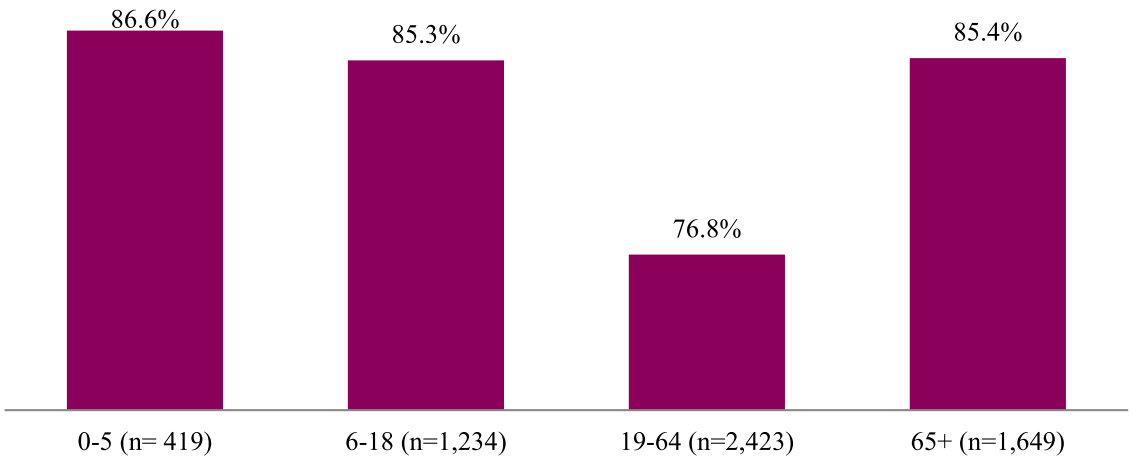
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

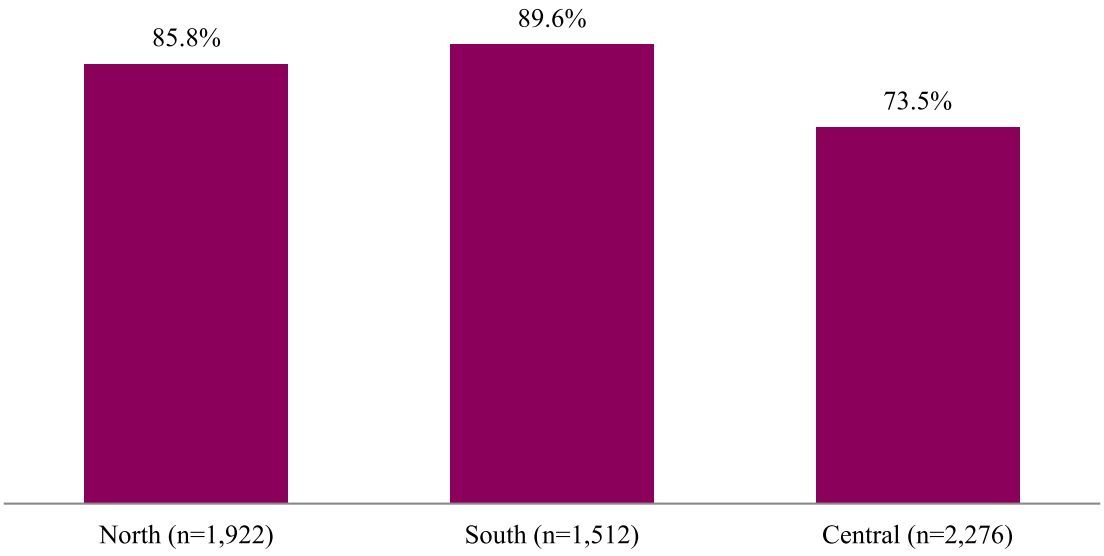


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

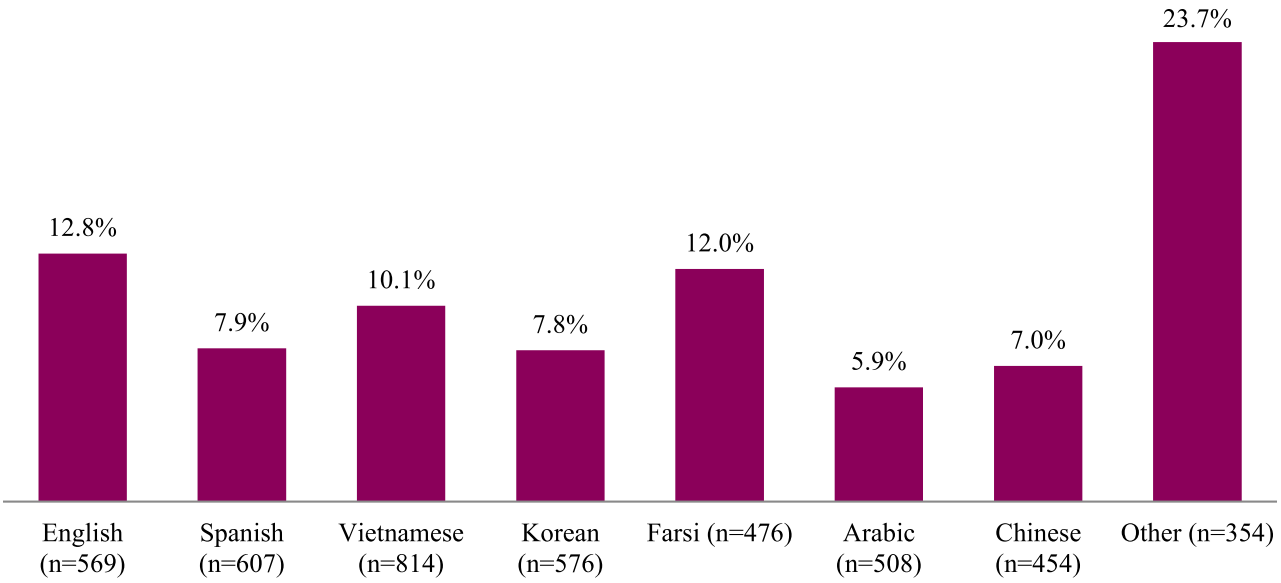
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

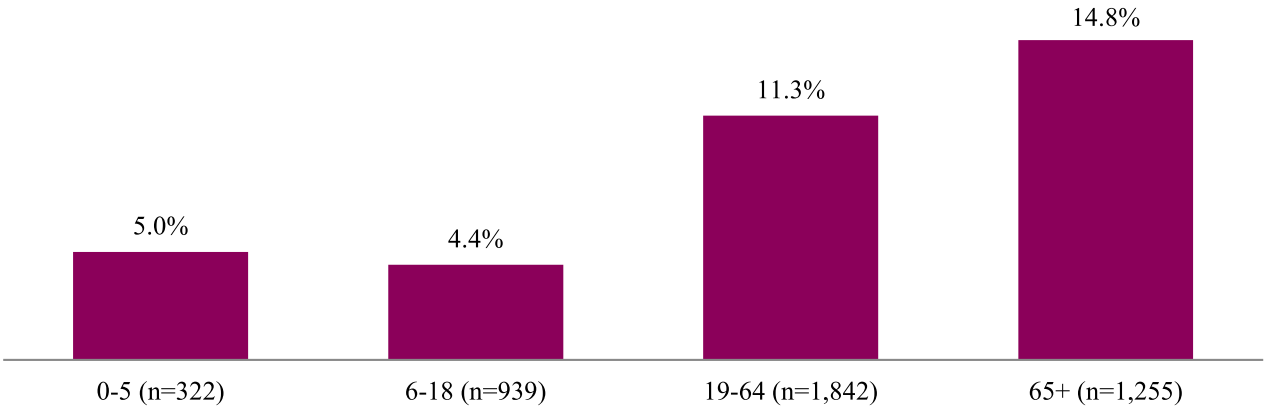
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

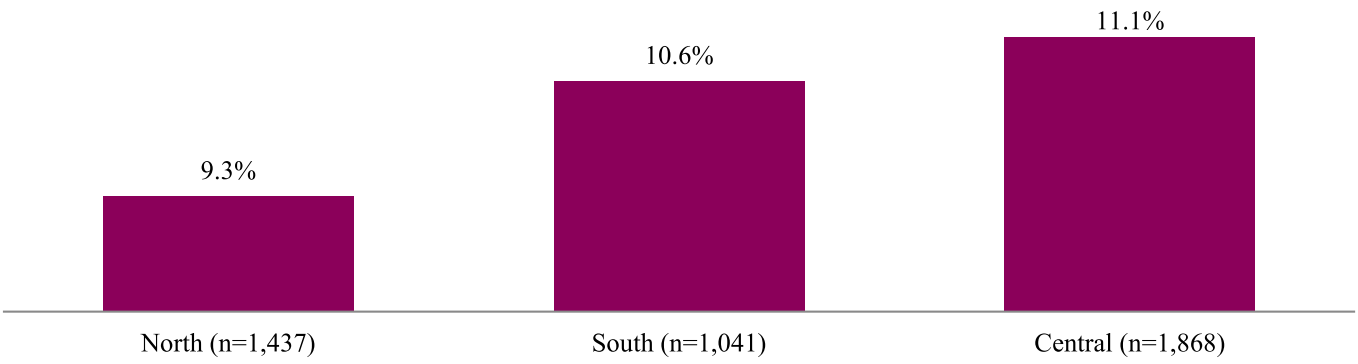
CalOptima language:



Age Category:



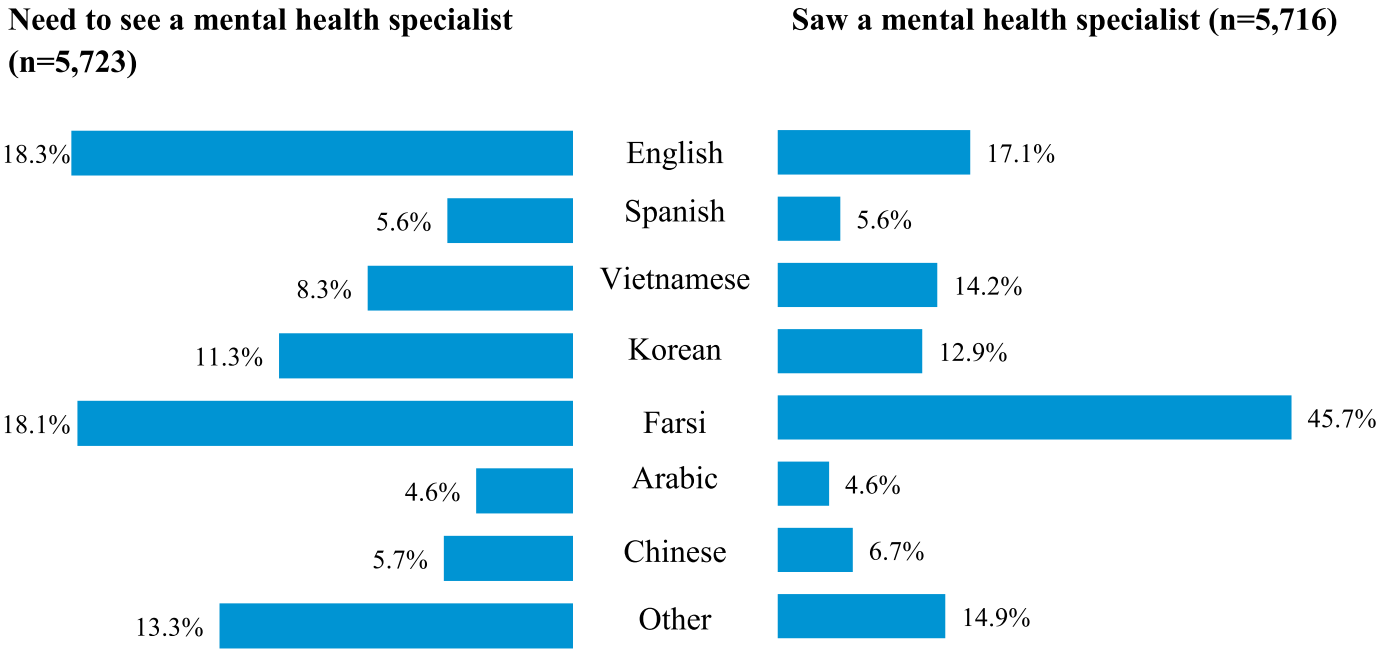
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

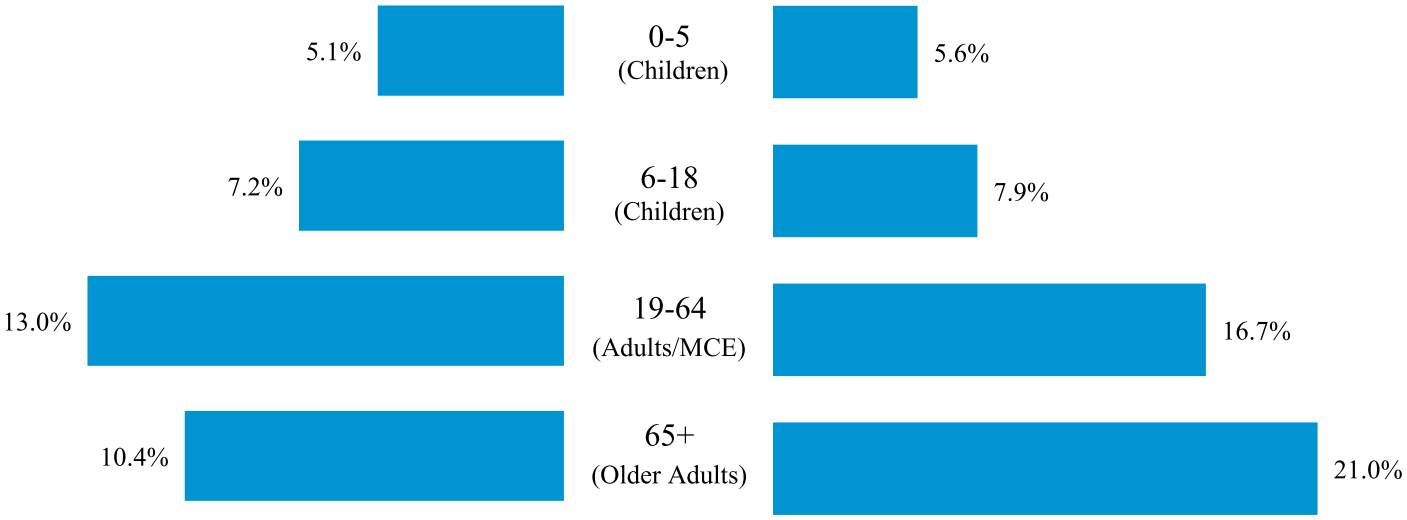


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

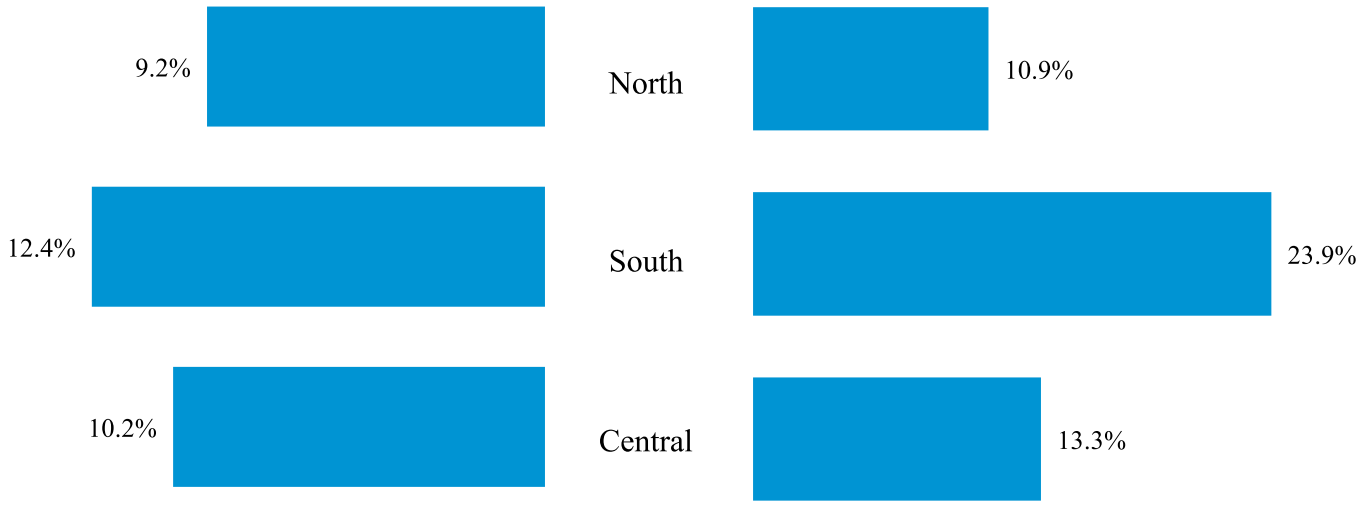
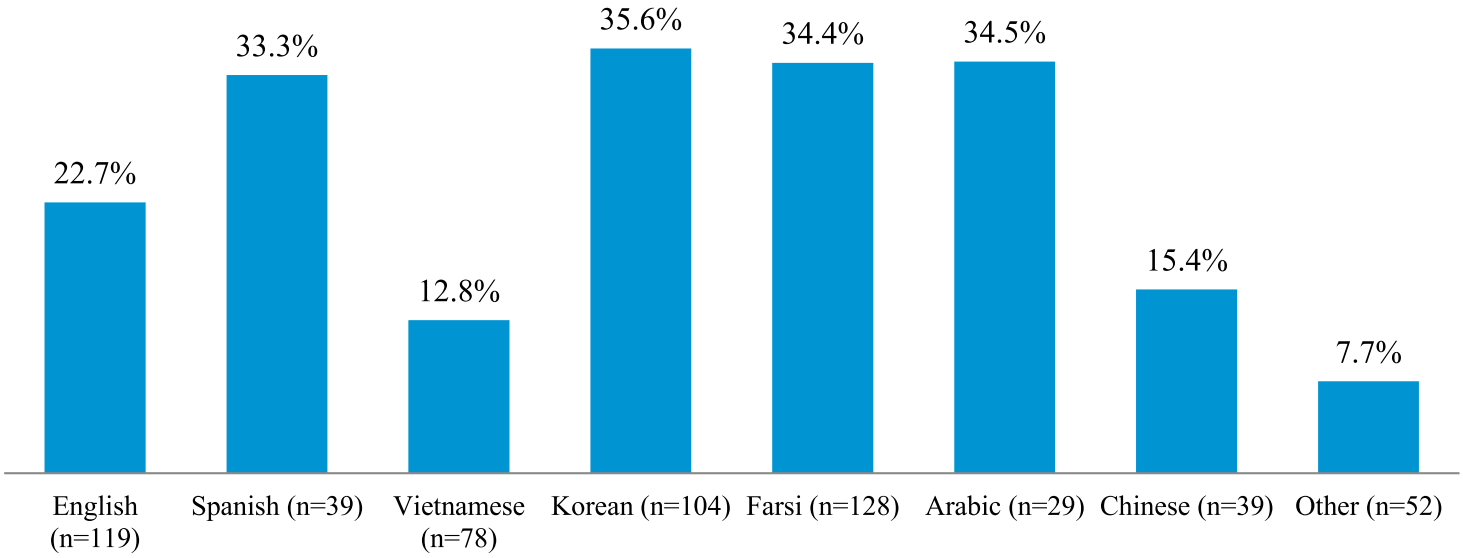
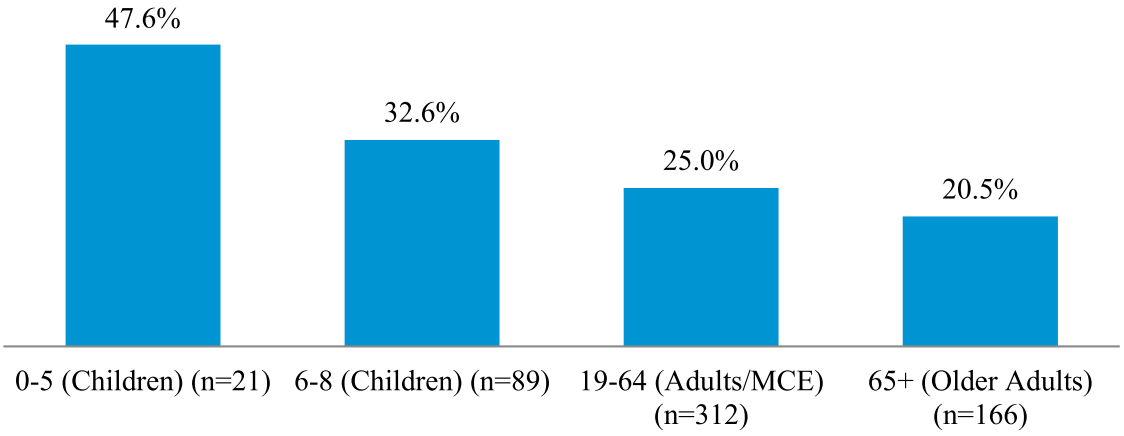


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

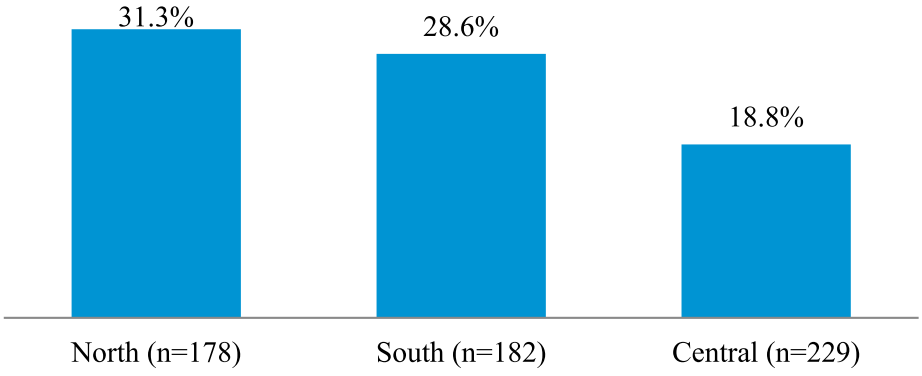
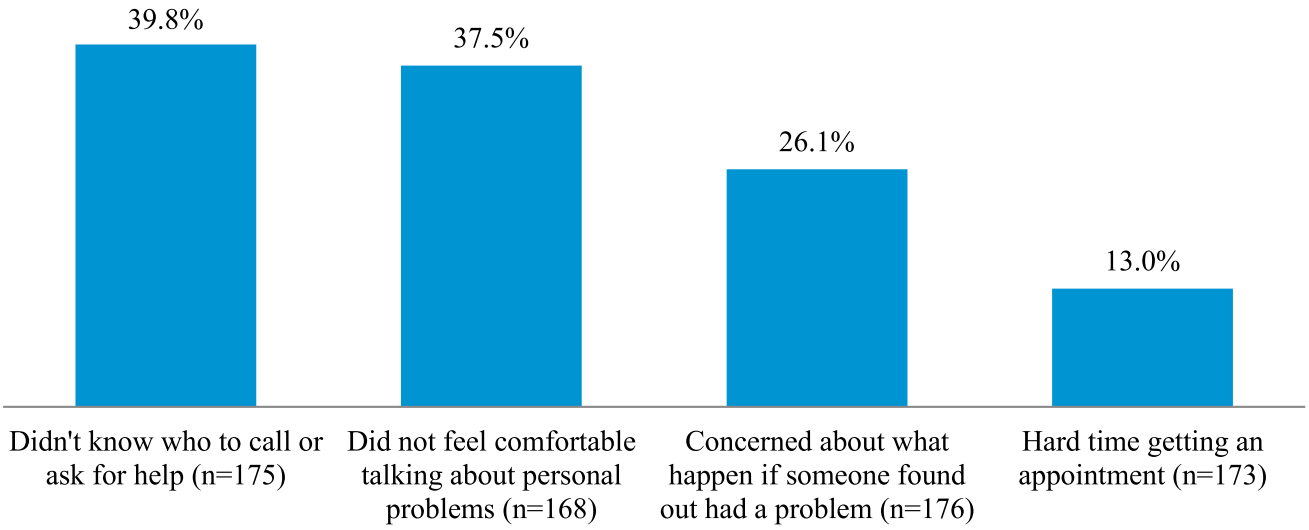


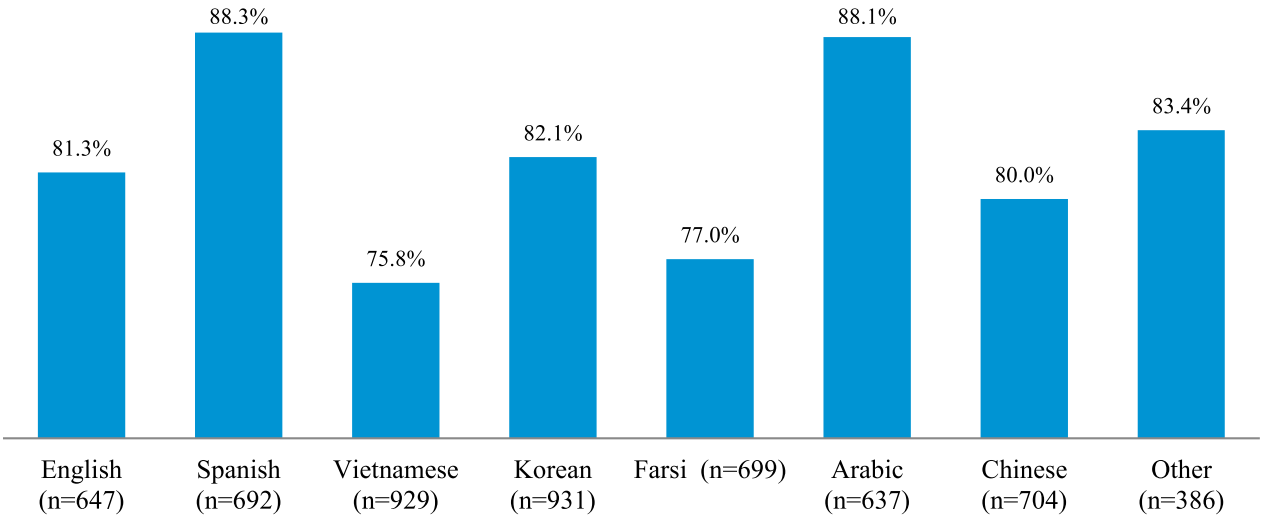
Exhibit 11. Reasons why members didn't see mental health specialist[7]



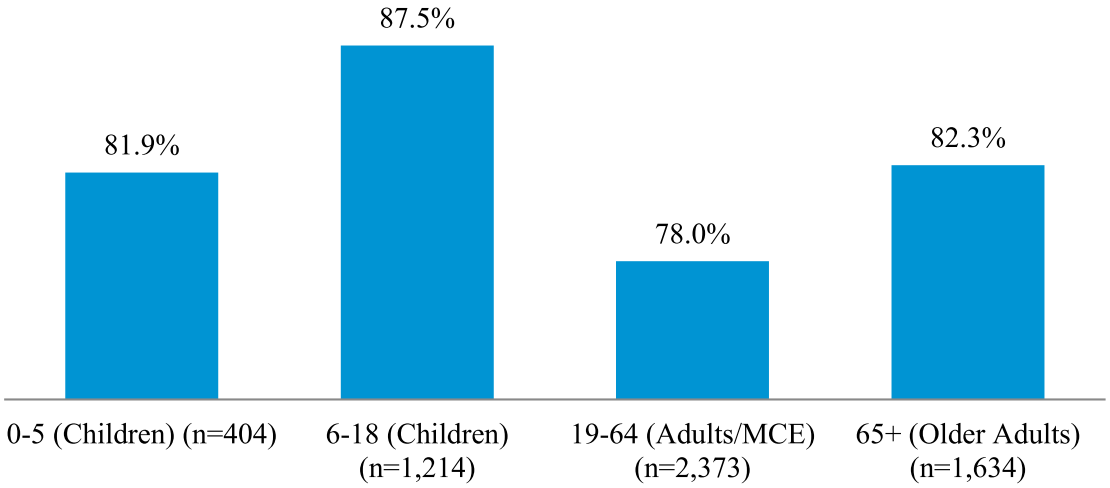
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

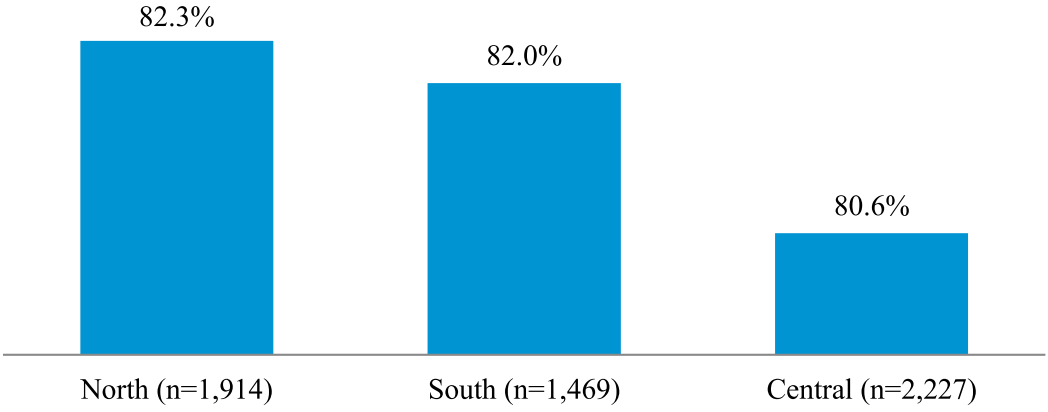
CalOptima language:



Age Category:



Region:

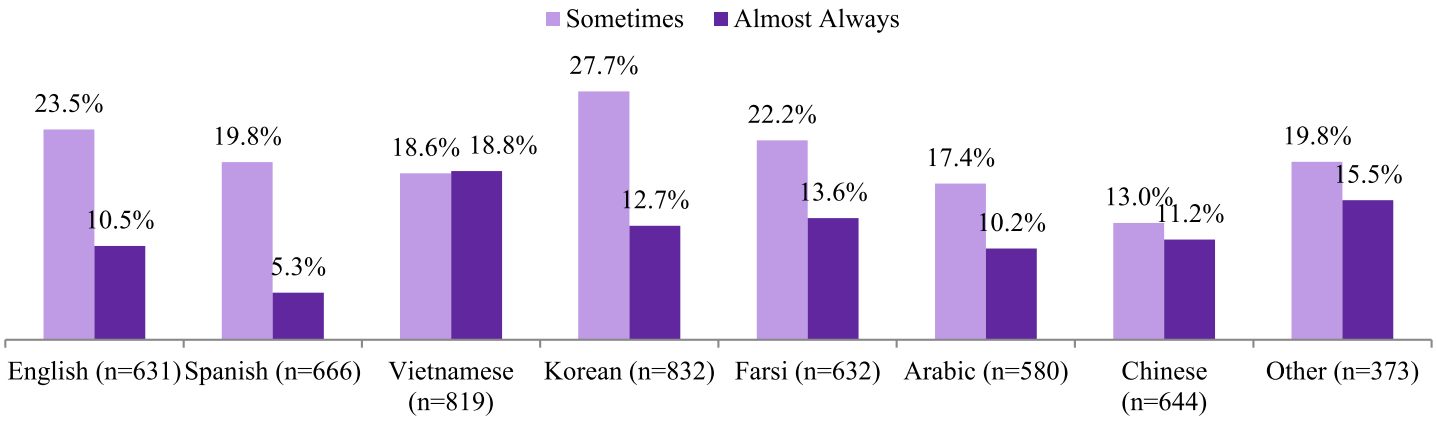


Social Determinants of Health

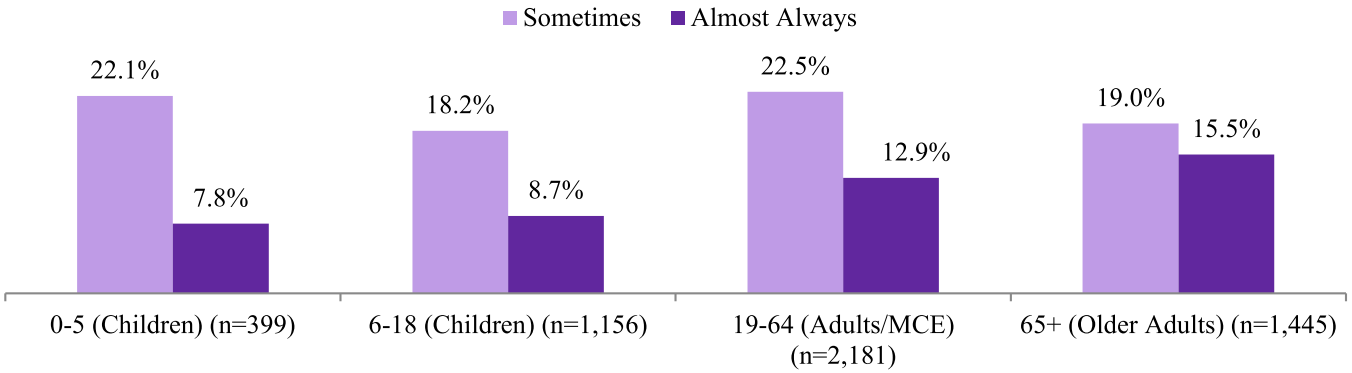
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

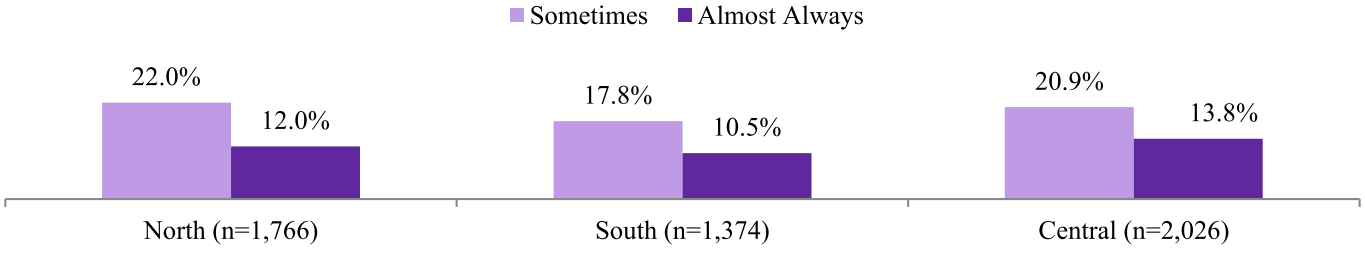
CalOptima language:



Age Category:

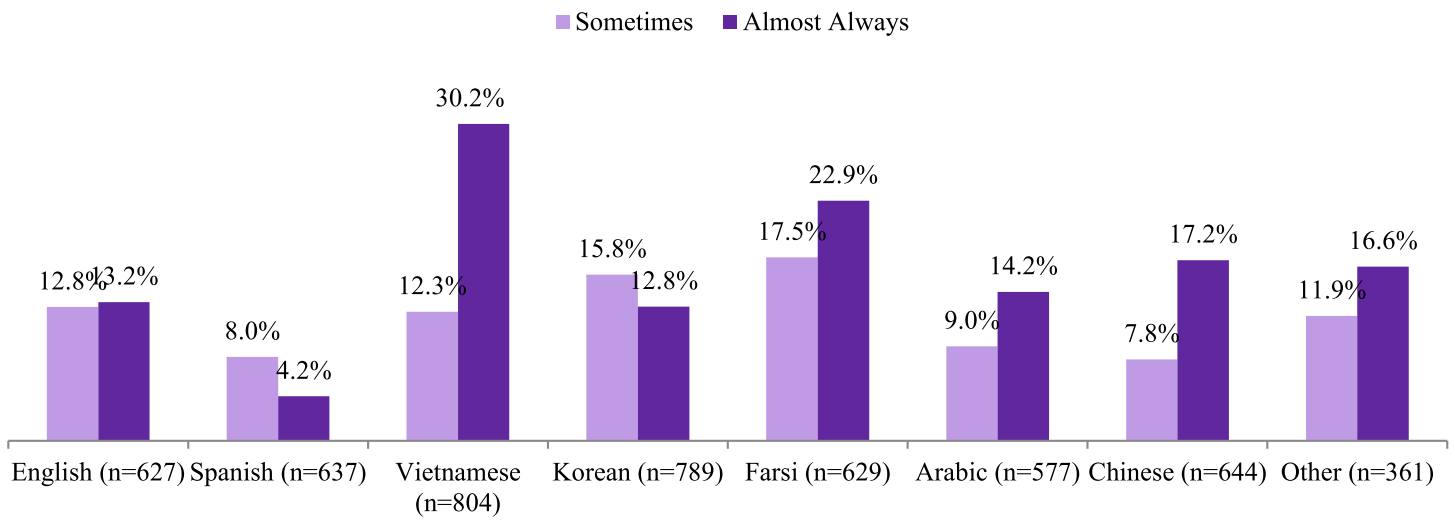


Region:

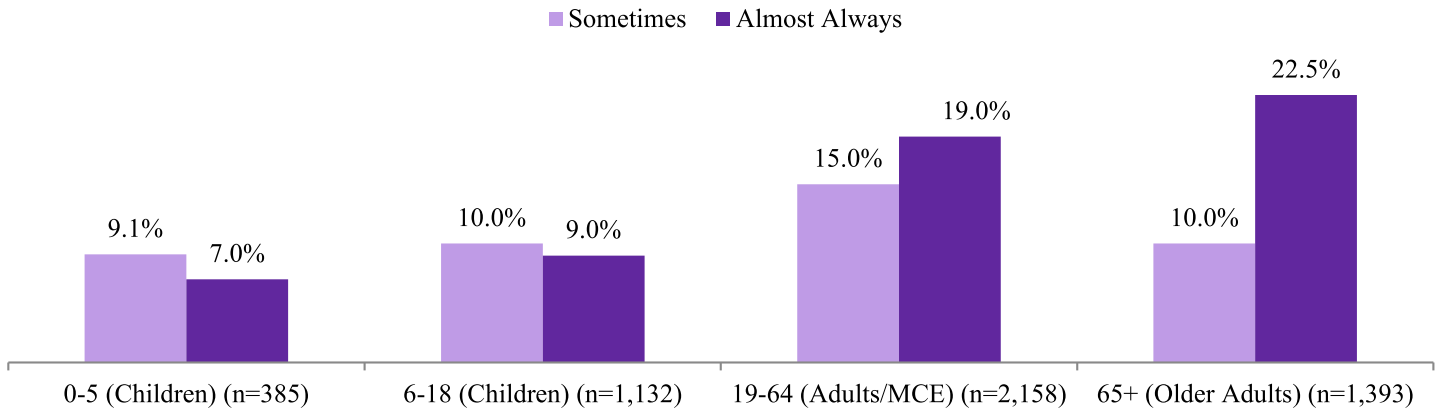


Housing:

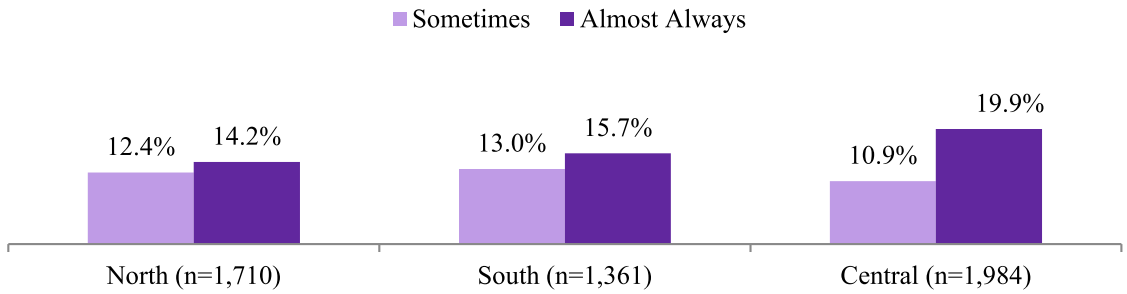
CalOptima language:



Age Category:

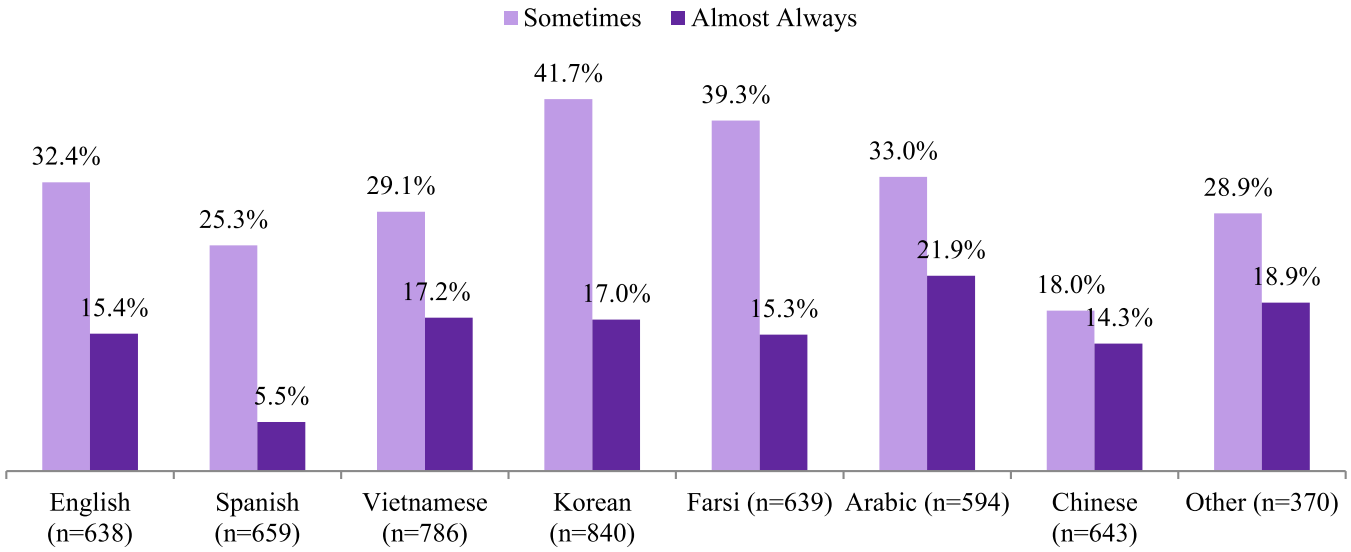


Region:

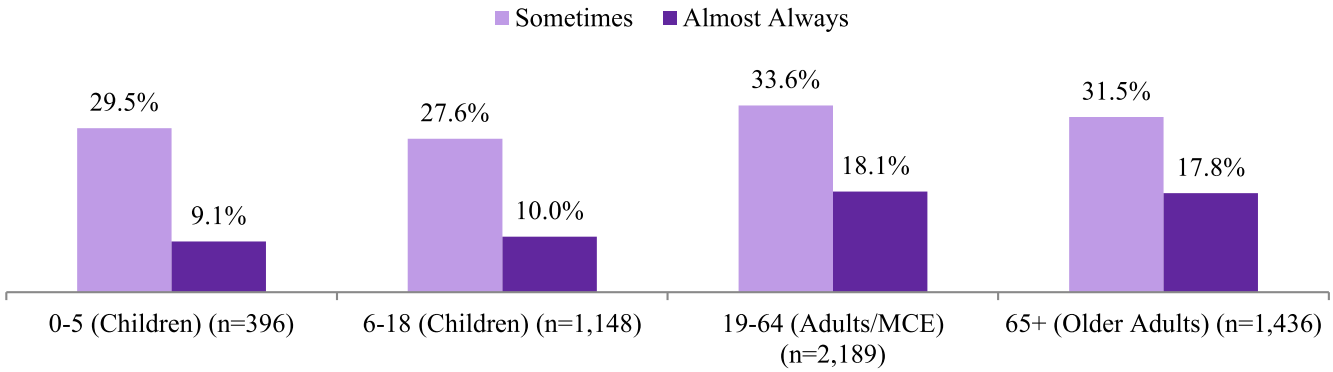


Money to buy things need:

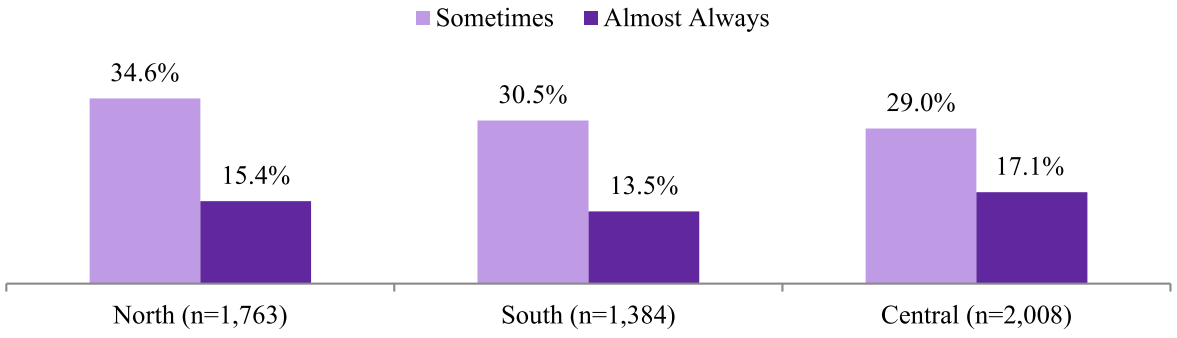
CalOptima language:



Age Category:

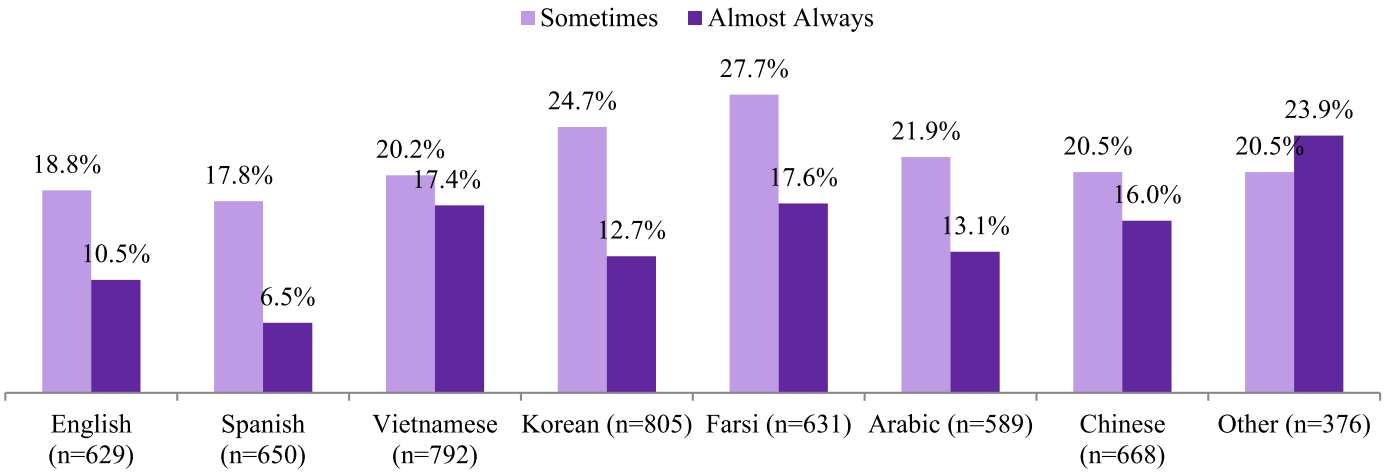


Region:

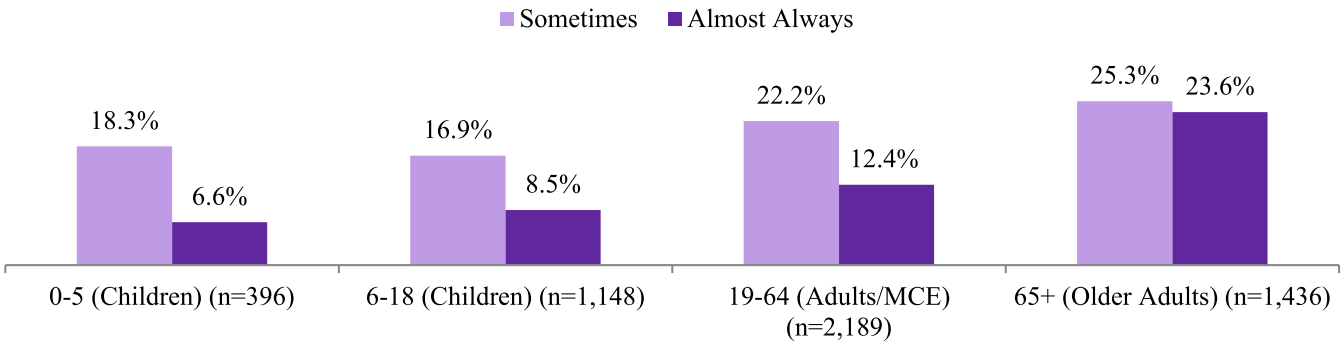


Transportation:

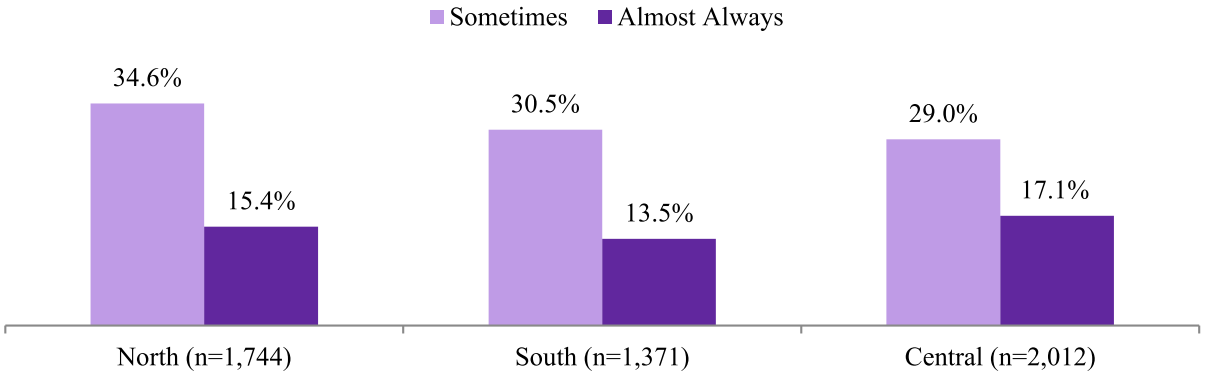
CalOptima language:



Age Category:

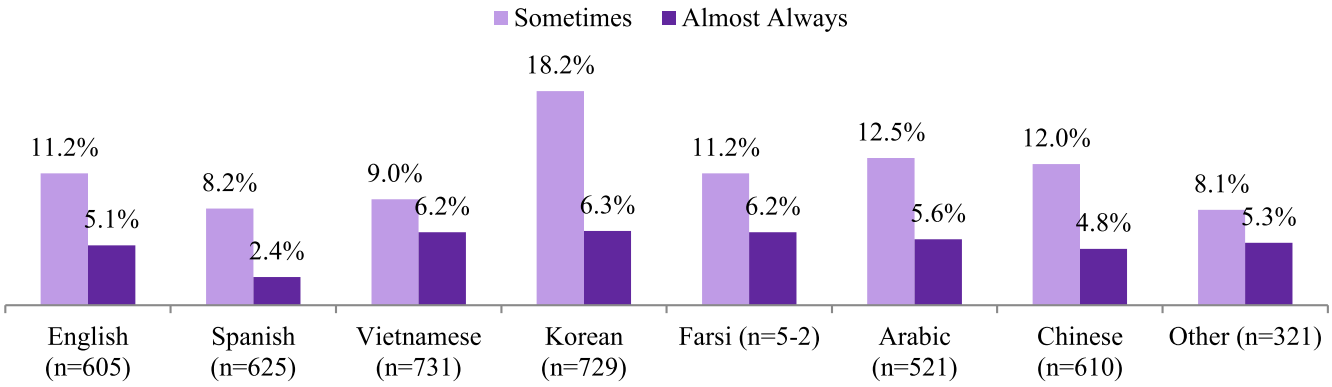


Region:

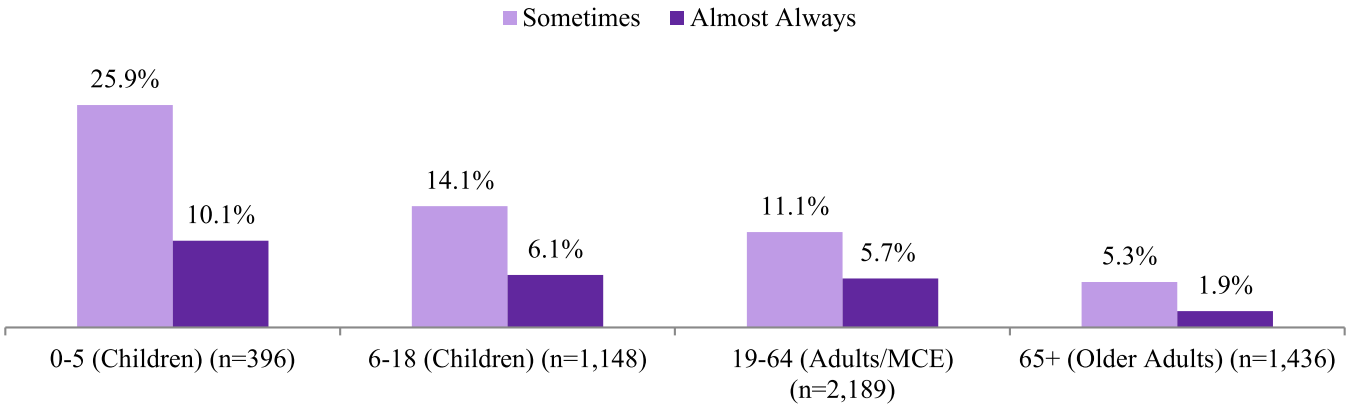


Child care:

CalOptima language:



Age Category:



Region:

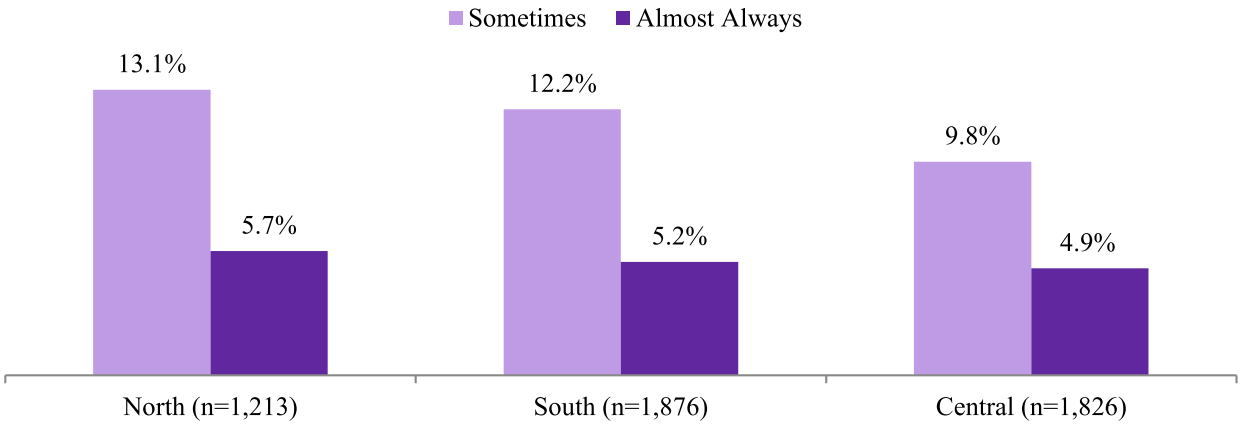
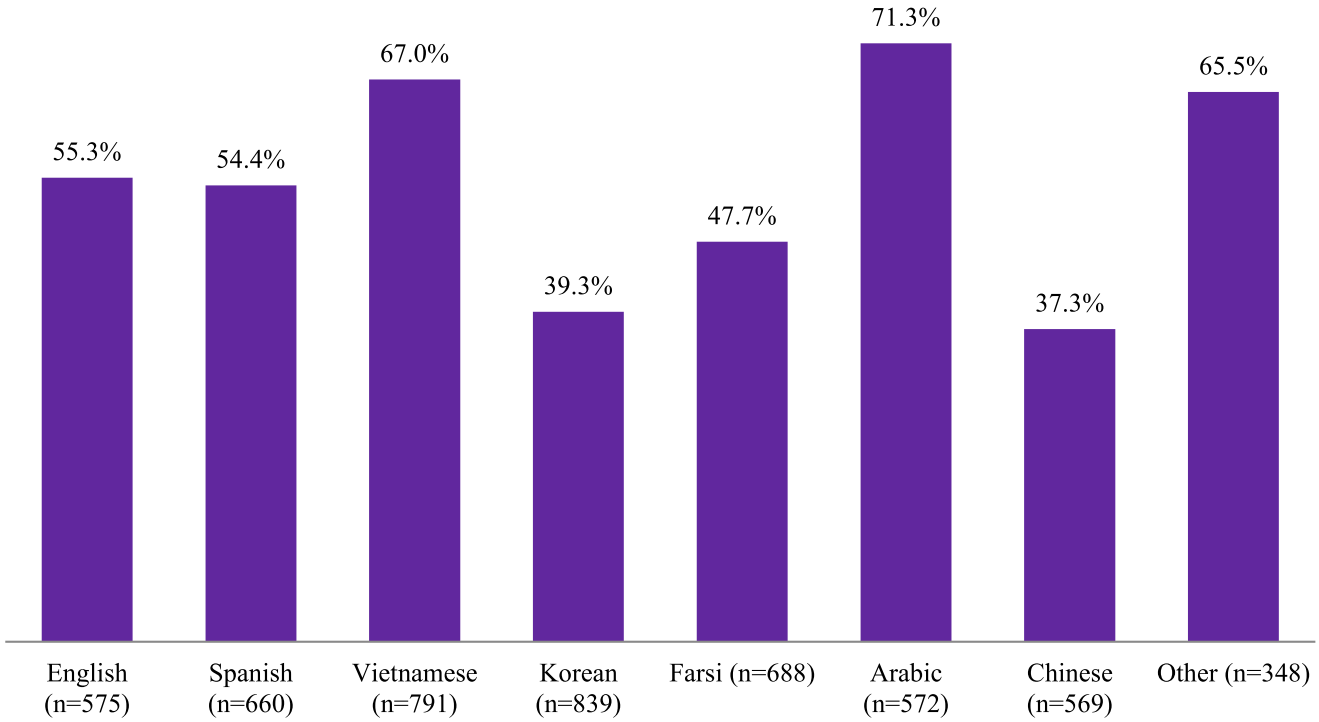


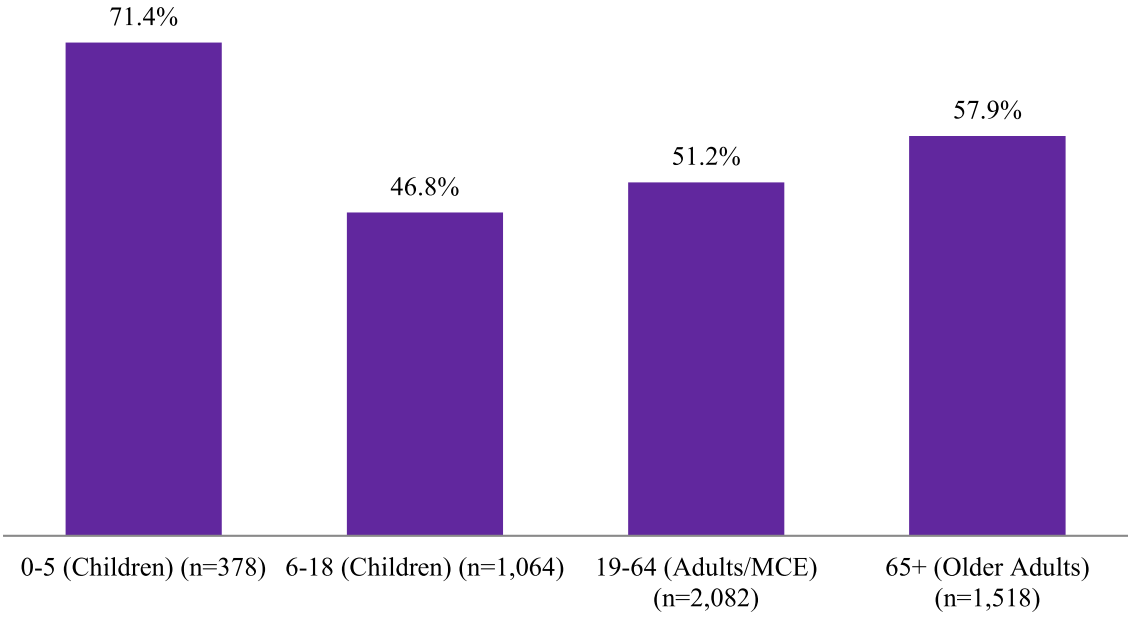
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

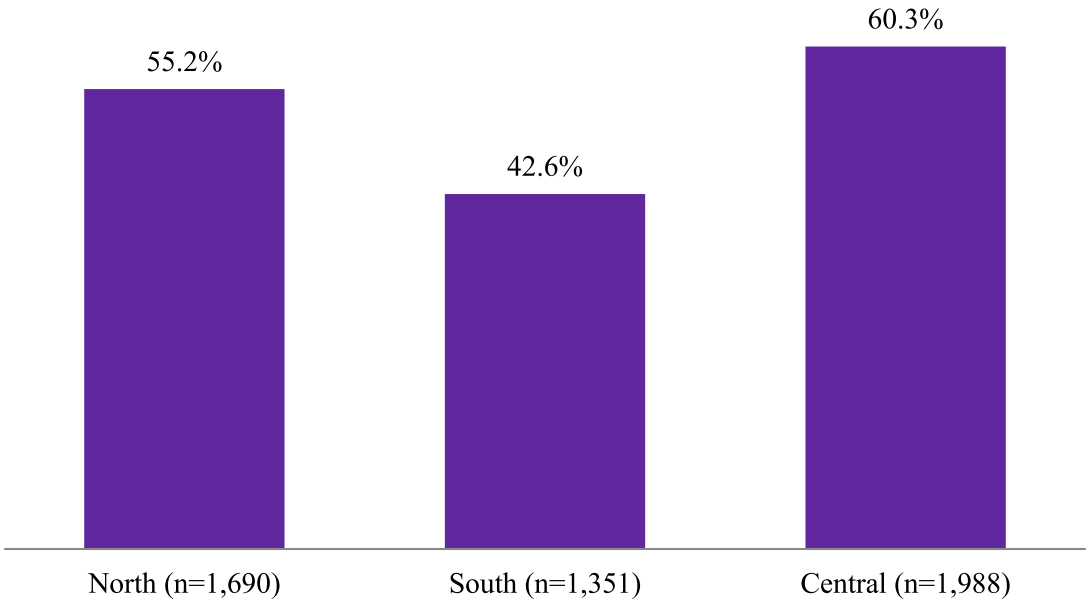
CalOptima language:



Age Category:



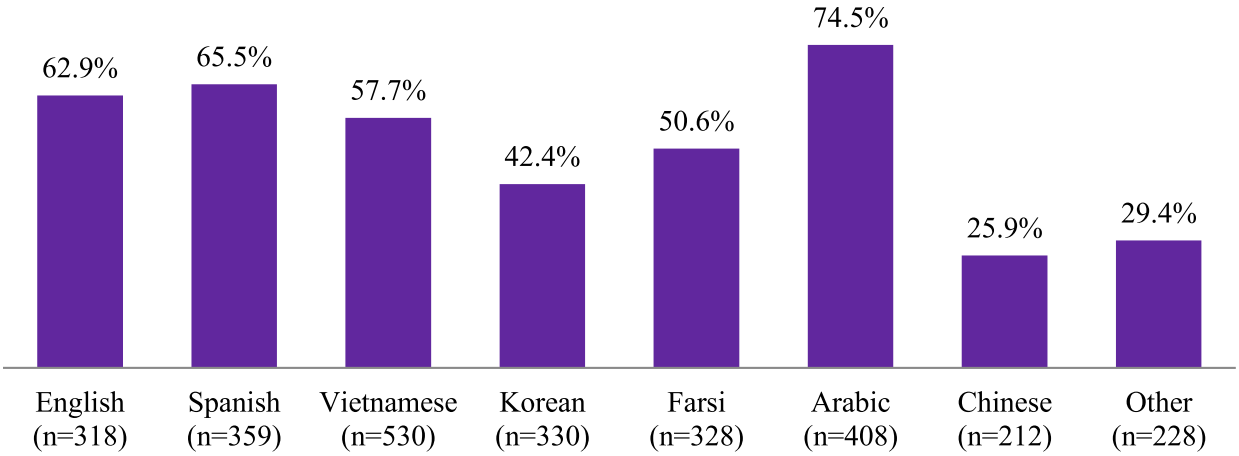
Region:



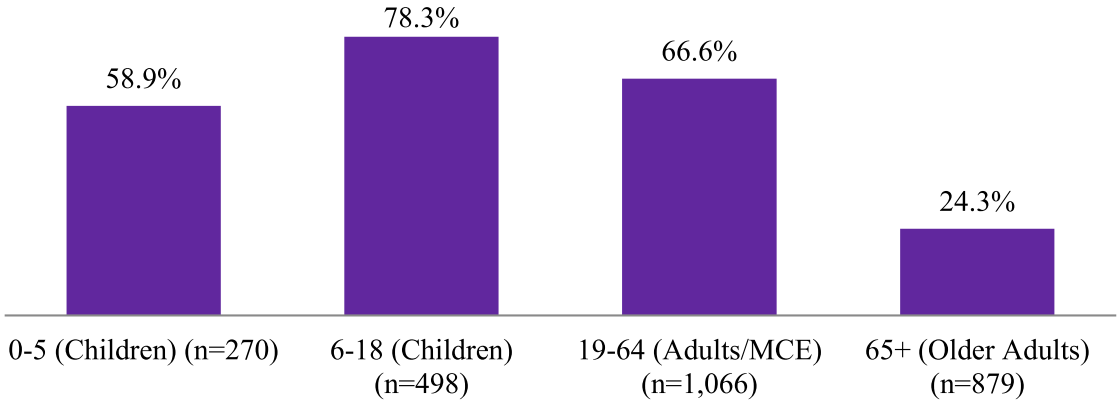
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

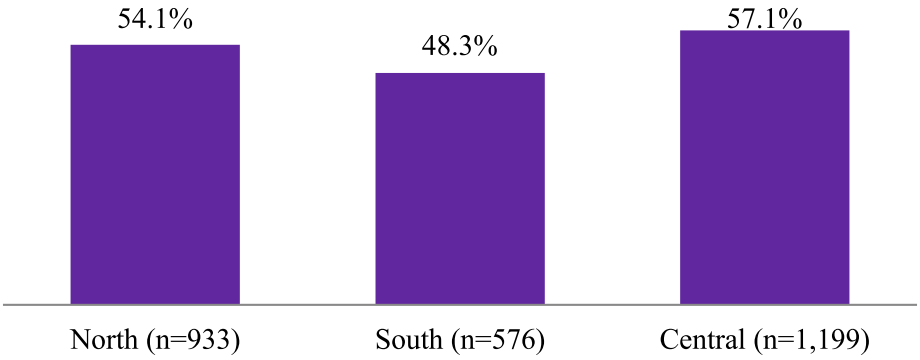
CalOptima language:



Age Category:



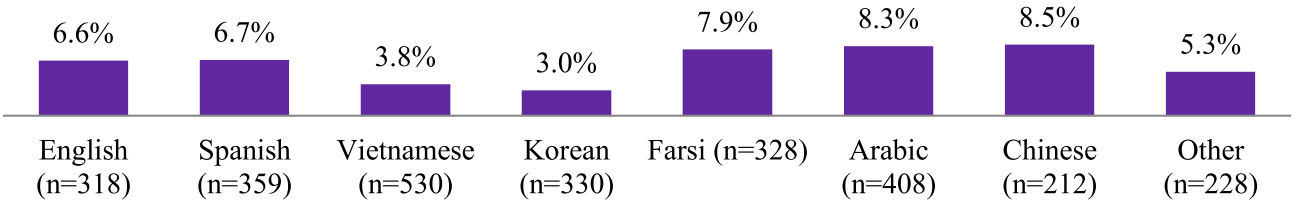
Region:



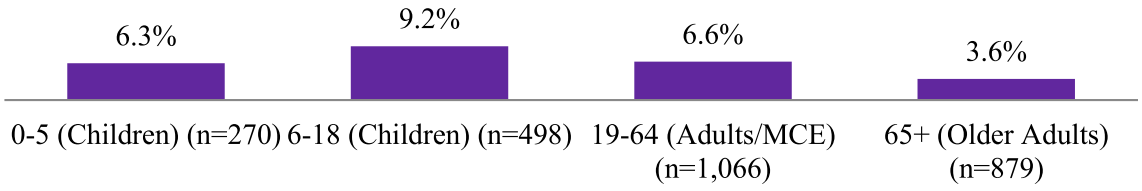
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

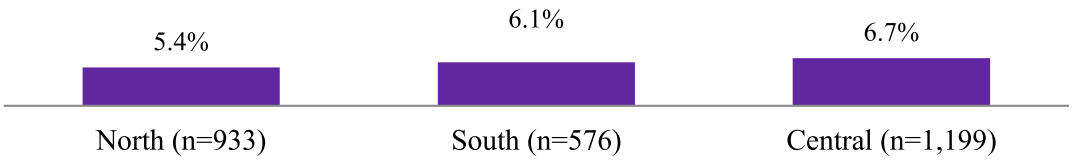
CalOptima language:



Age Category:

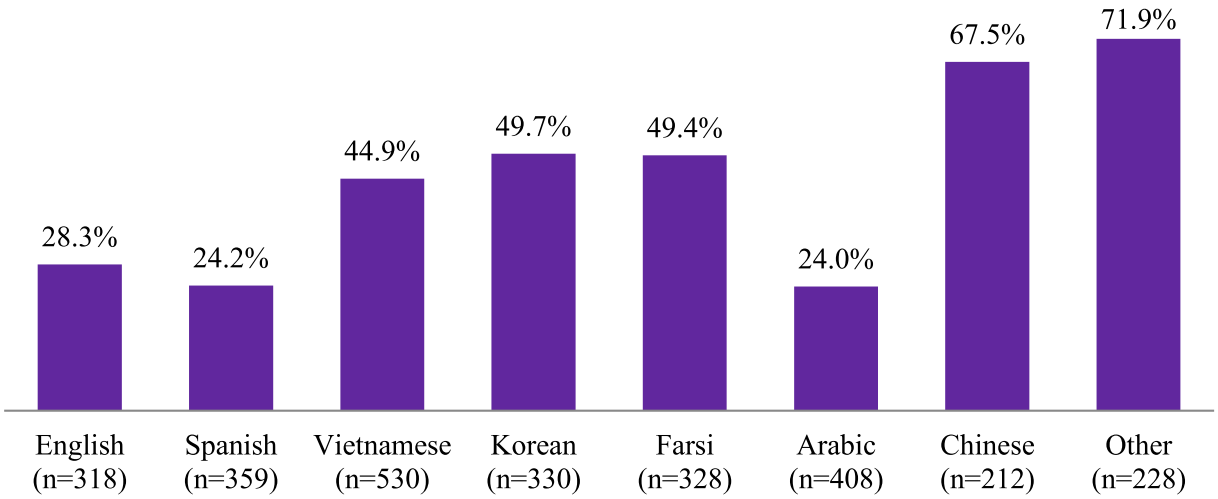


Region:

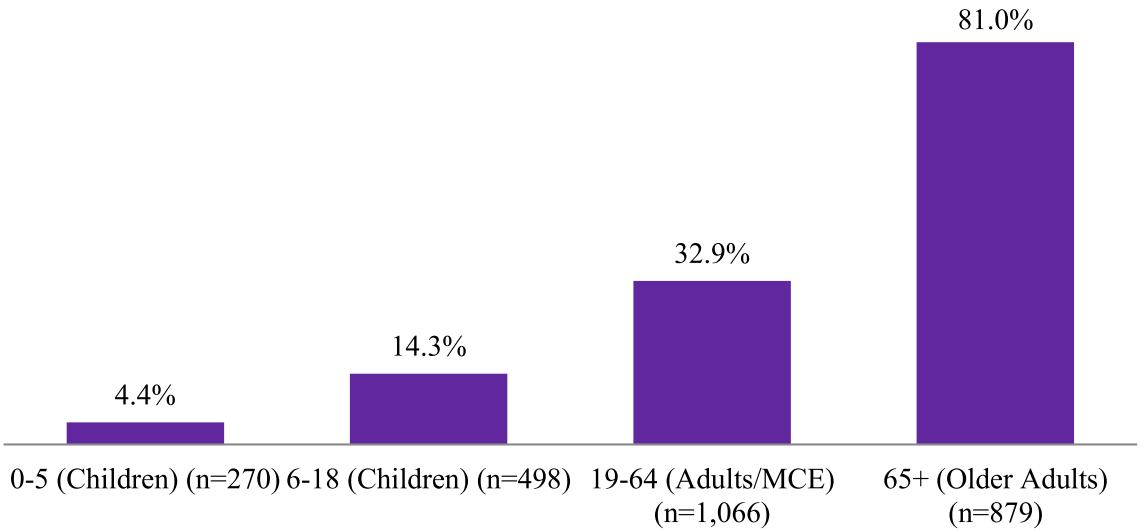


Receive SSI or SSDI as a public benefit:

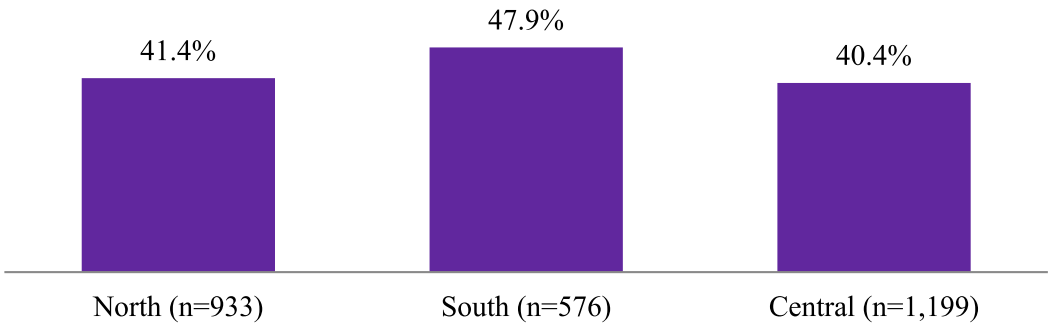
CalOptima language:



Age Category:

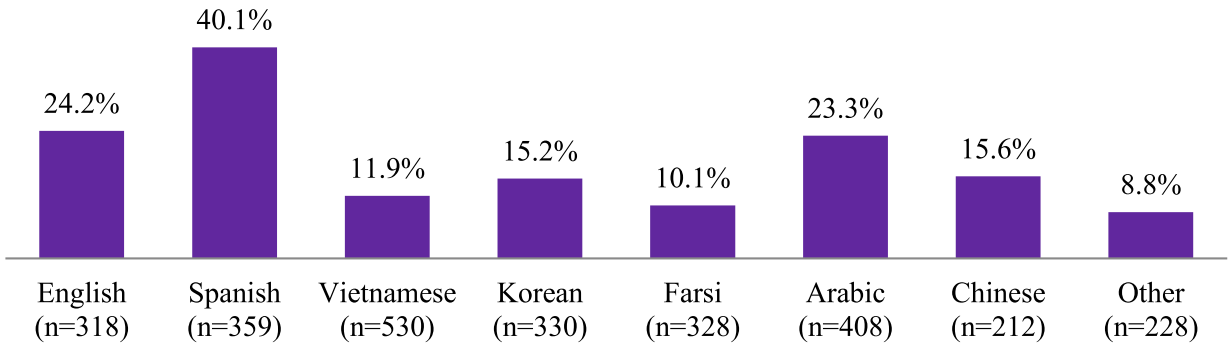


Region:

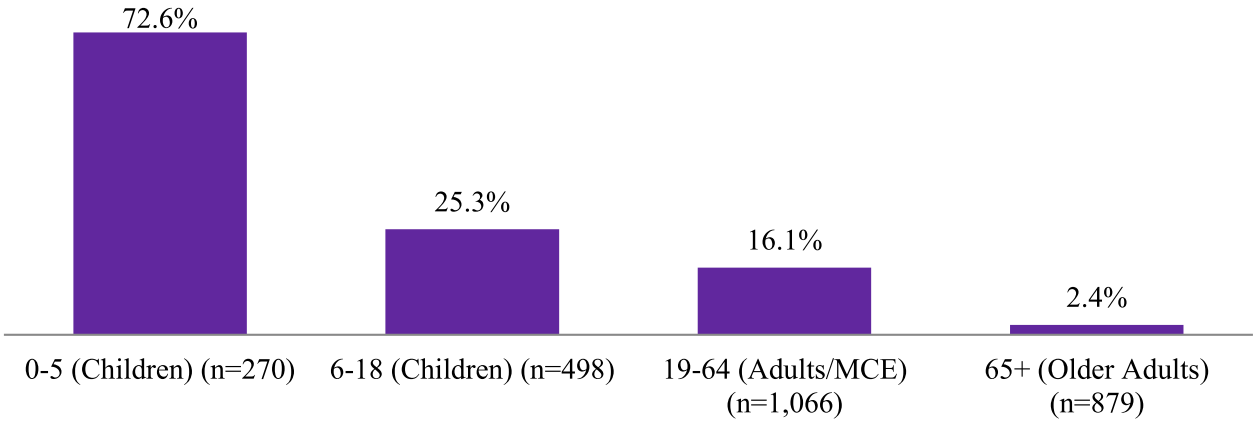


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

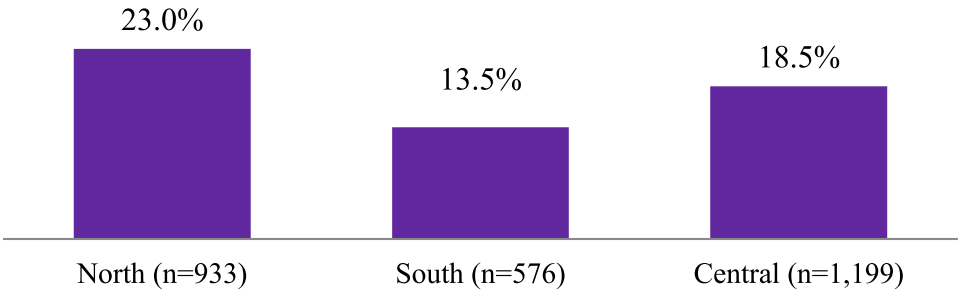


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401
Volunteer or charity	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467
Get enough sleep	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249
Have enough time for self	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

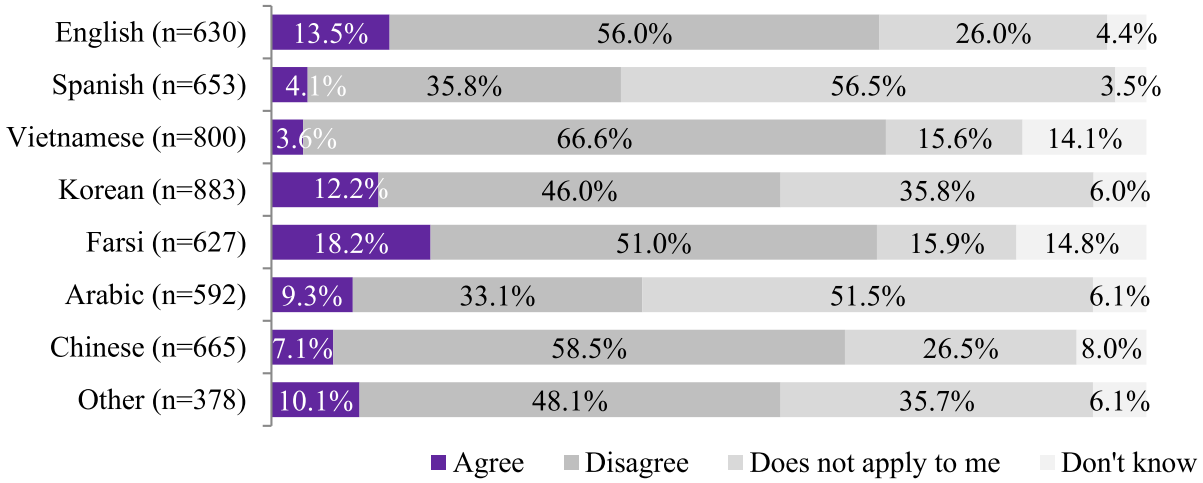
Have enough time for self	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

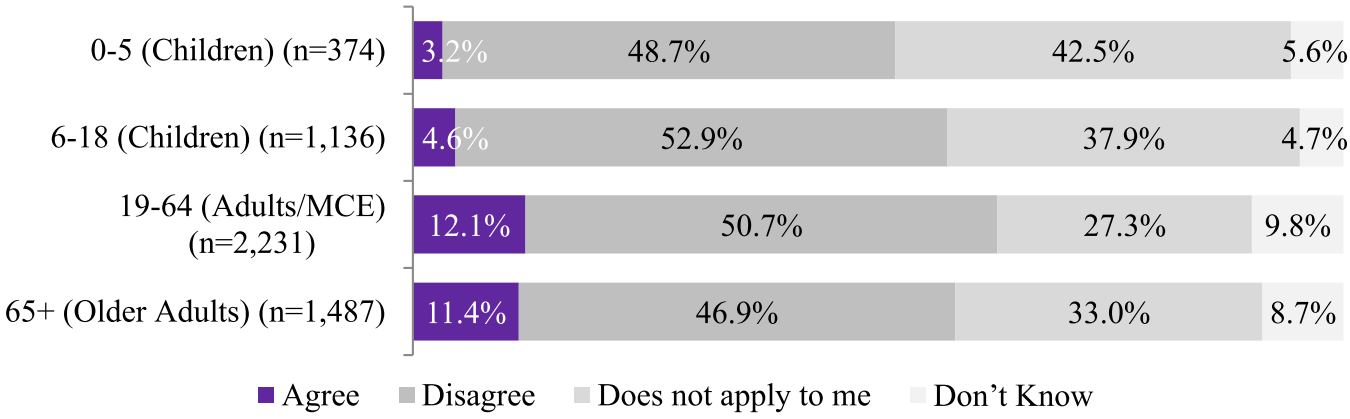
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

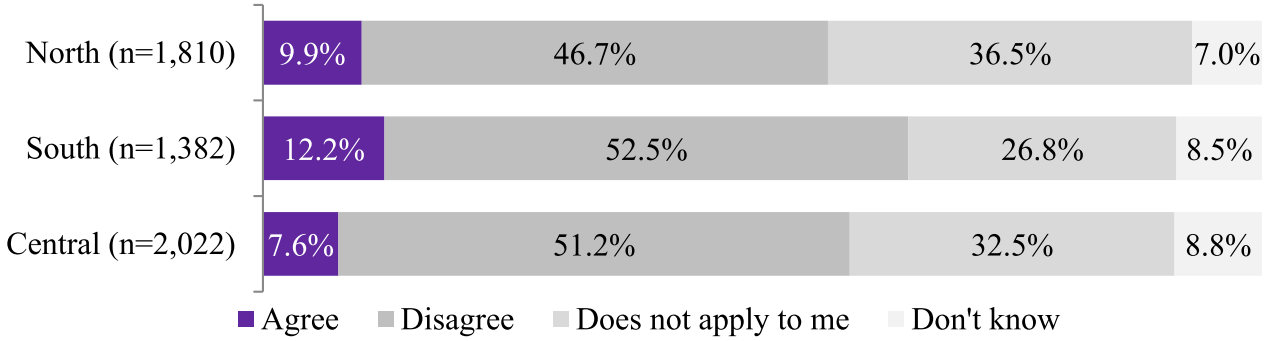
CalOptima language:



Age Category:

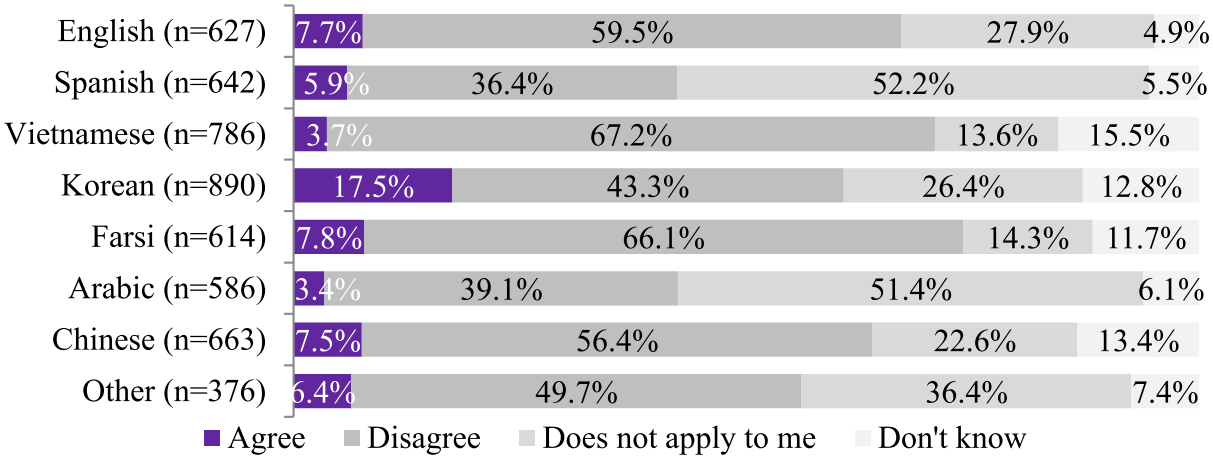


Region:

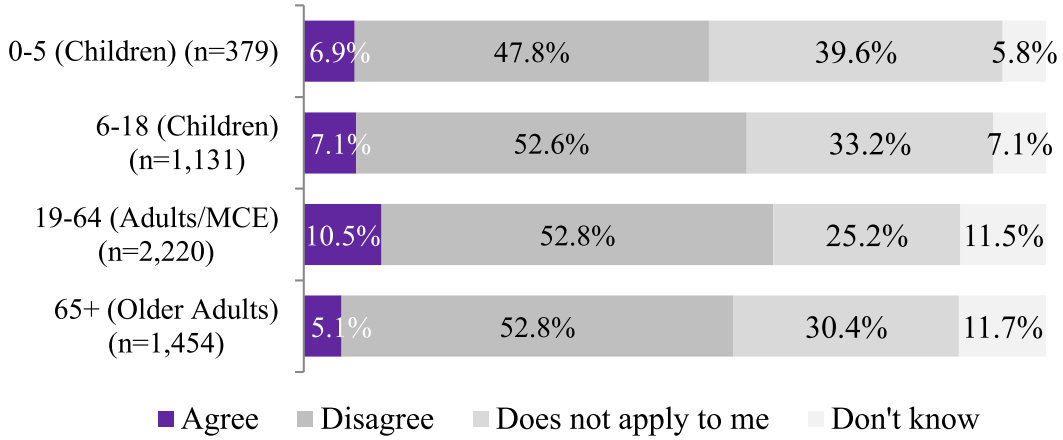


Feel not treated equally because of ethnic and culutral backgrounds:

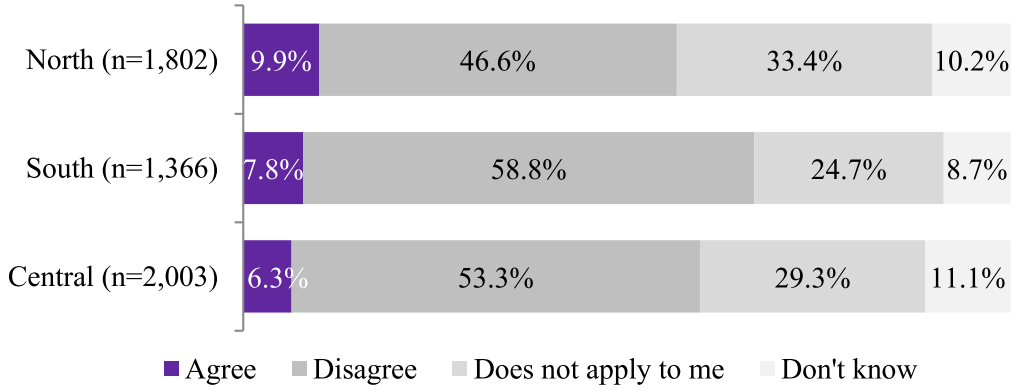
CalOptima language:



Age Category:

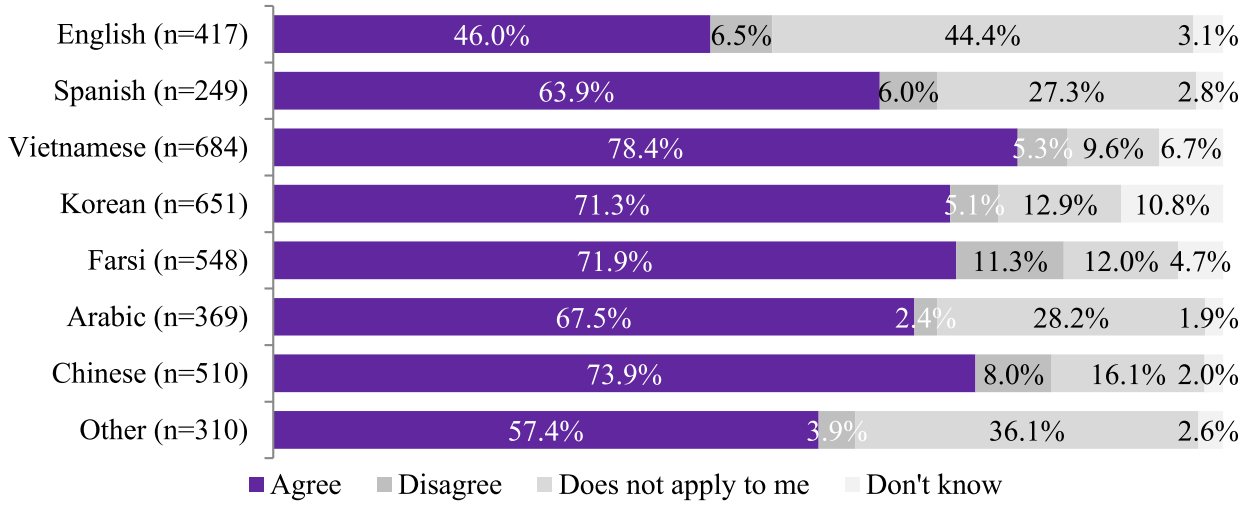


Region:

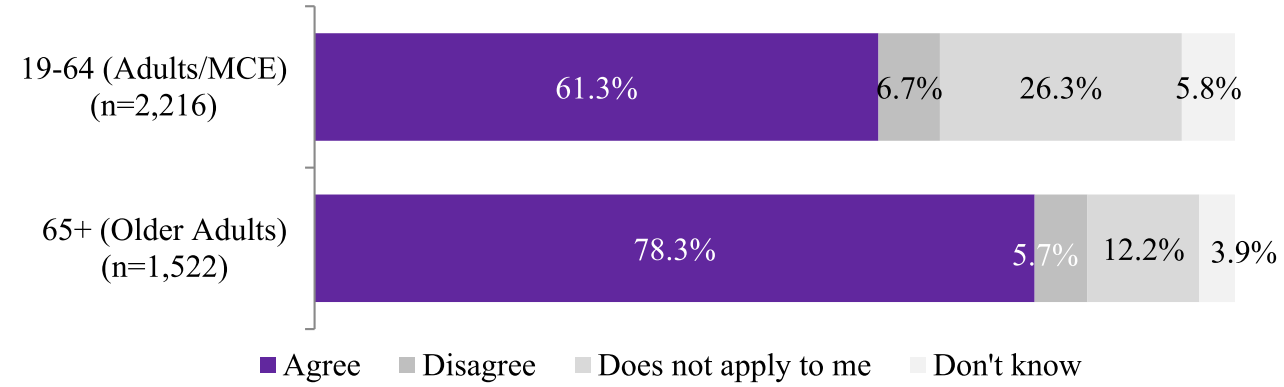


Feel child respects them as a parent[9]:

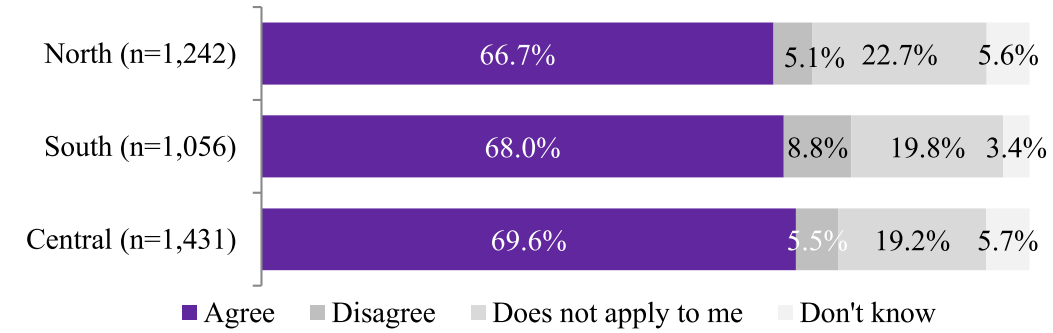
CalOptima language:



Age Category:



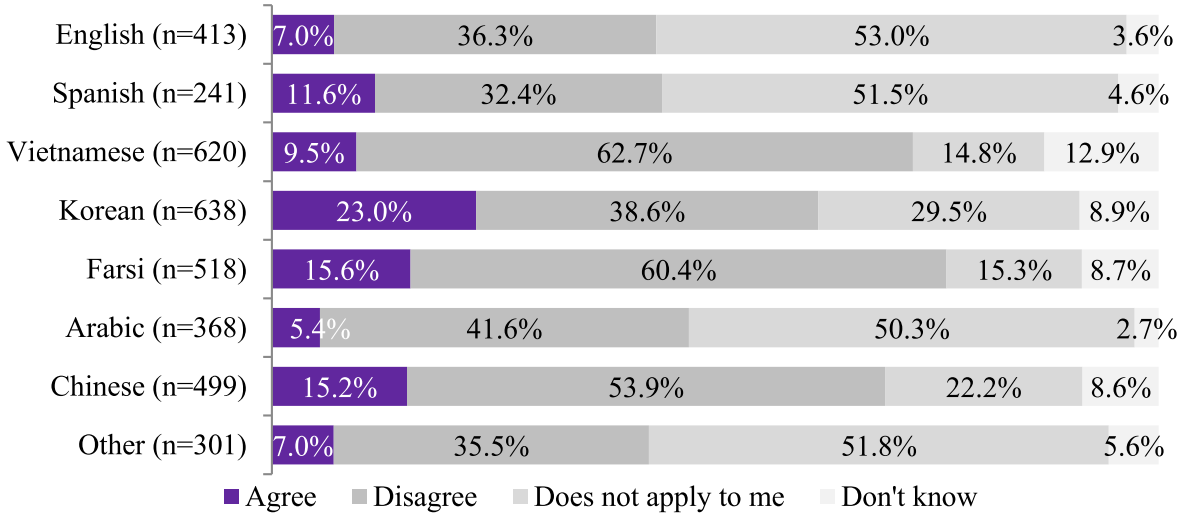
Region:



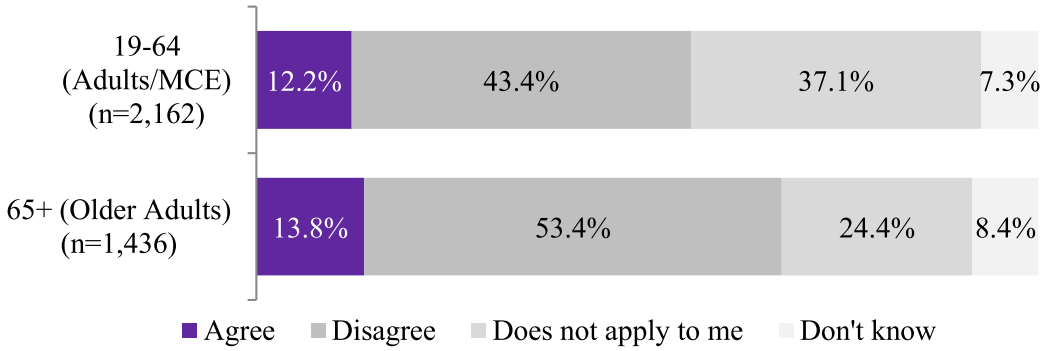
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

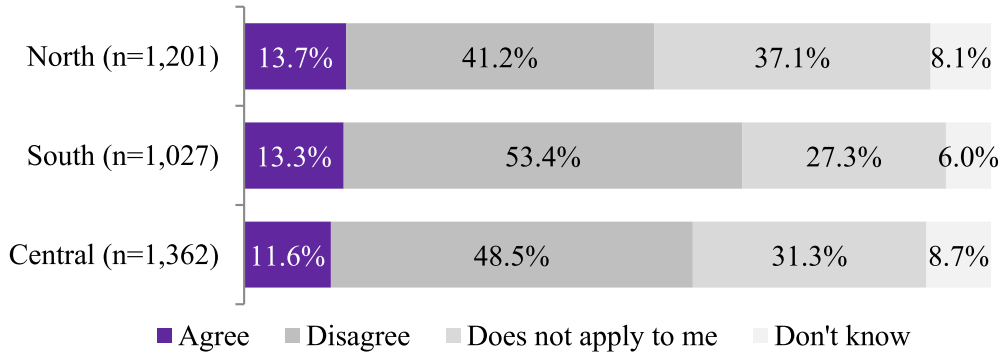
CalOptima language:



Age Category:



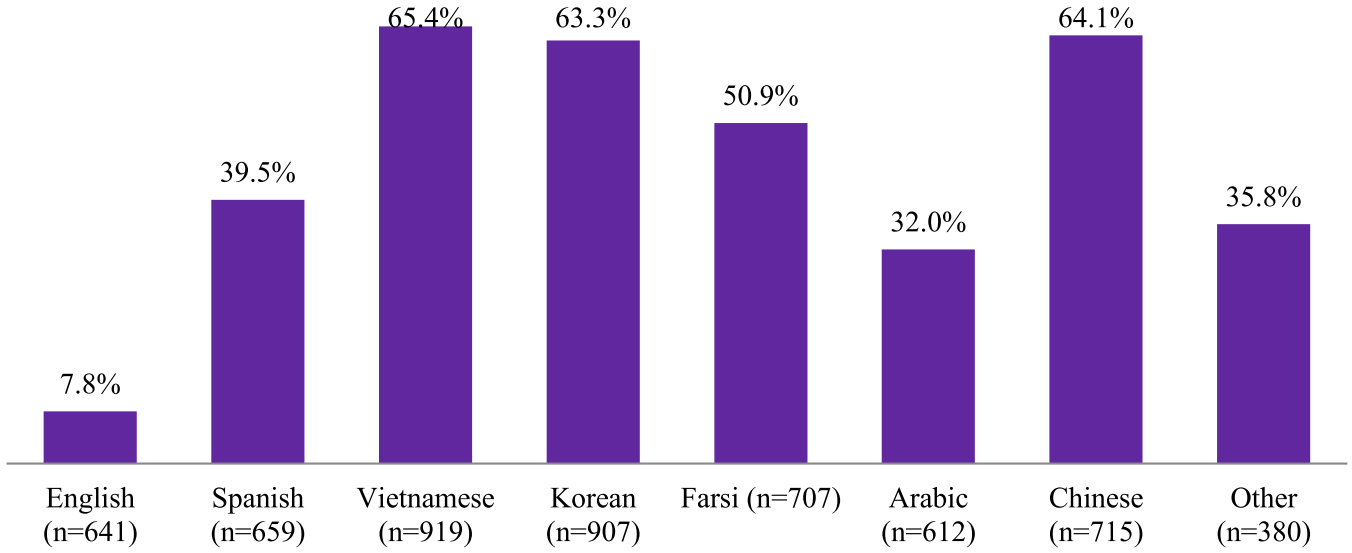
Region:



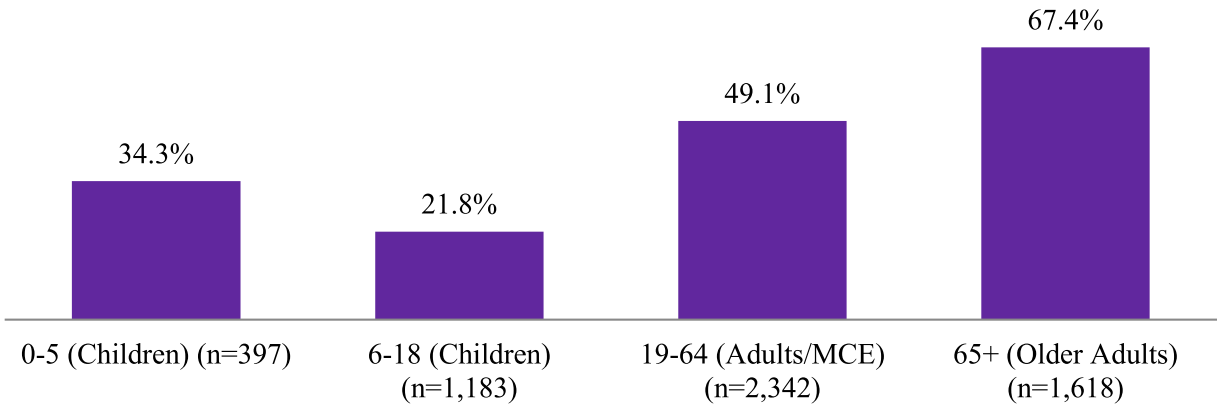
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

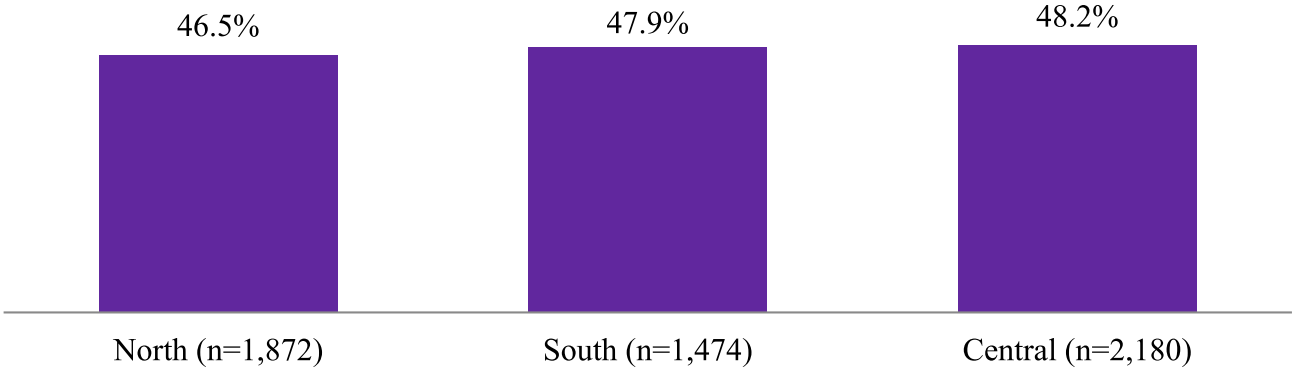


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

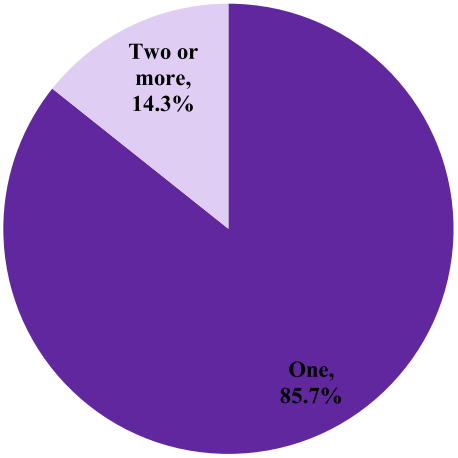
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

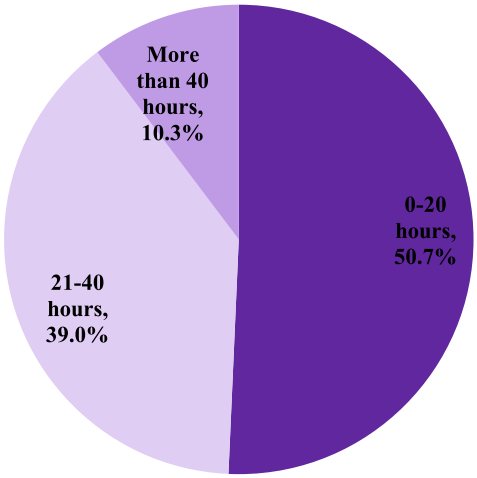
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

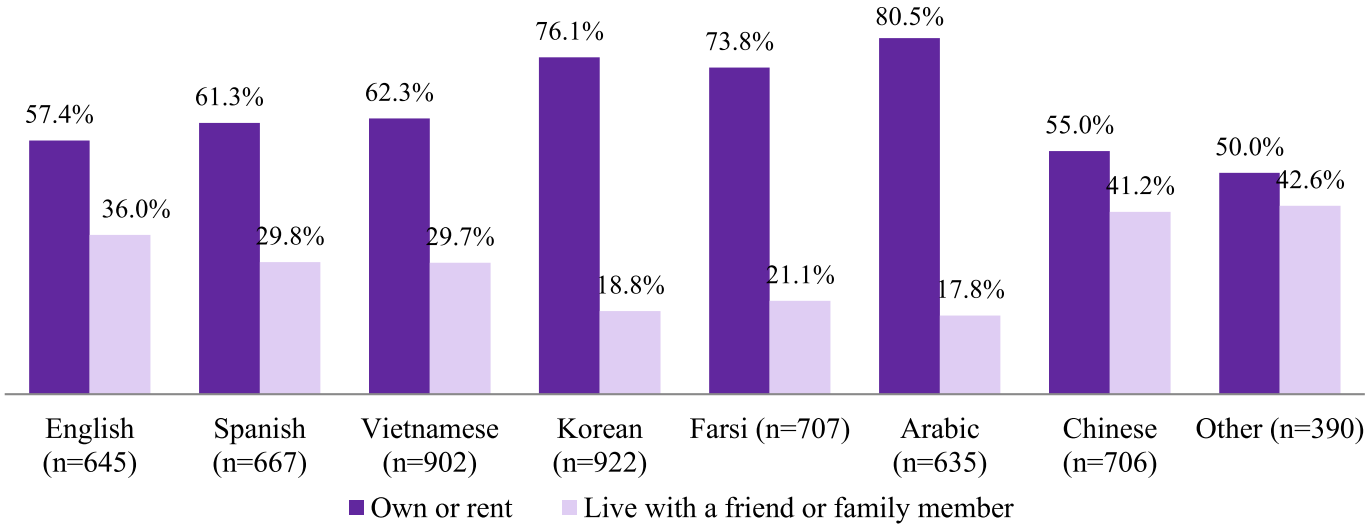


Number of hours that members work each week

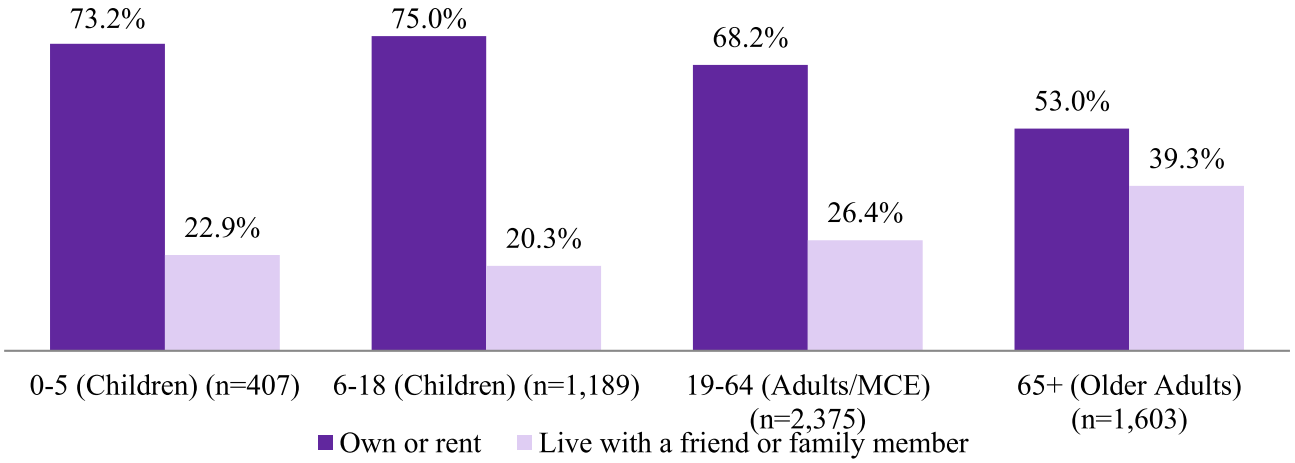


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

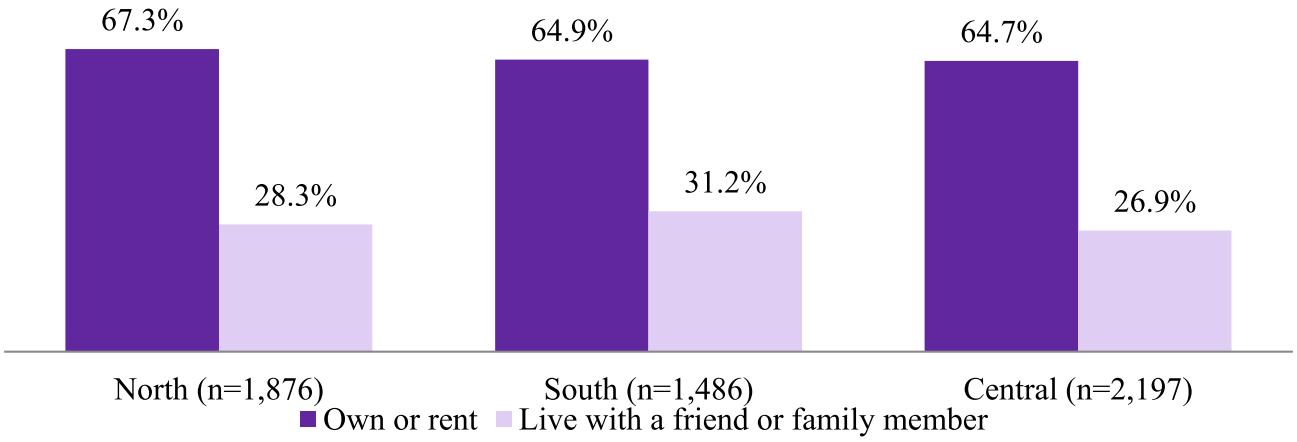
Exhibit 20. Members' living situation[14]



Age Category:



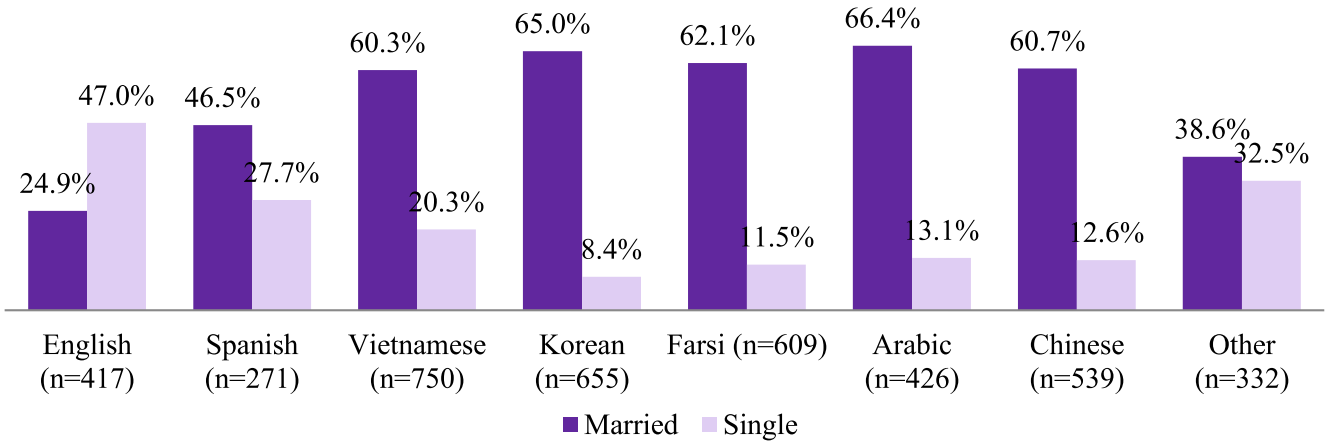
Region:



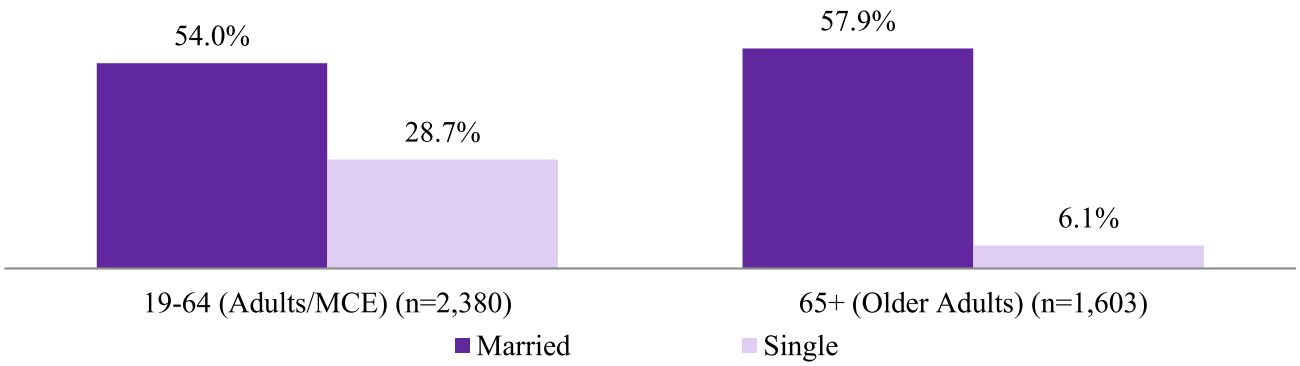
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

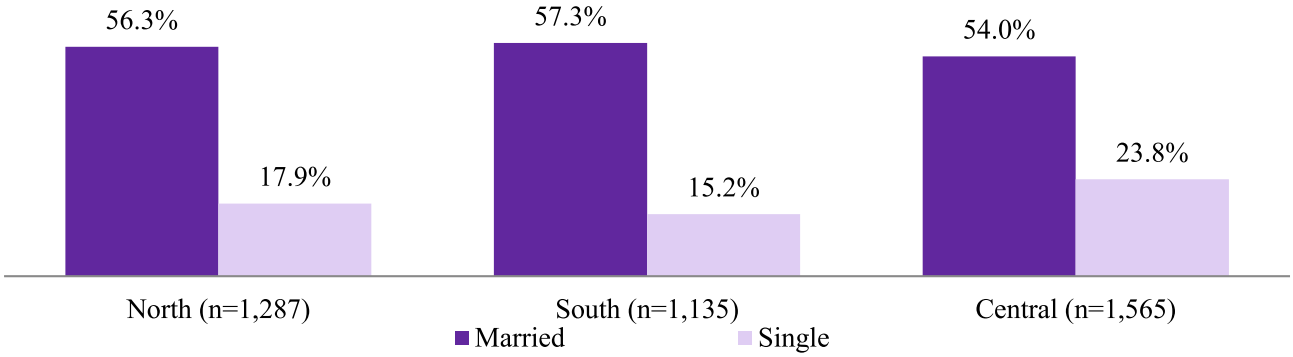
CalOptima language:



Age Category:



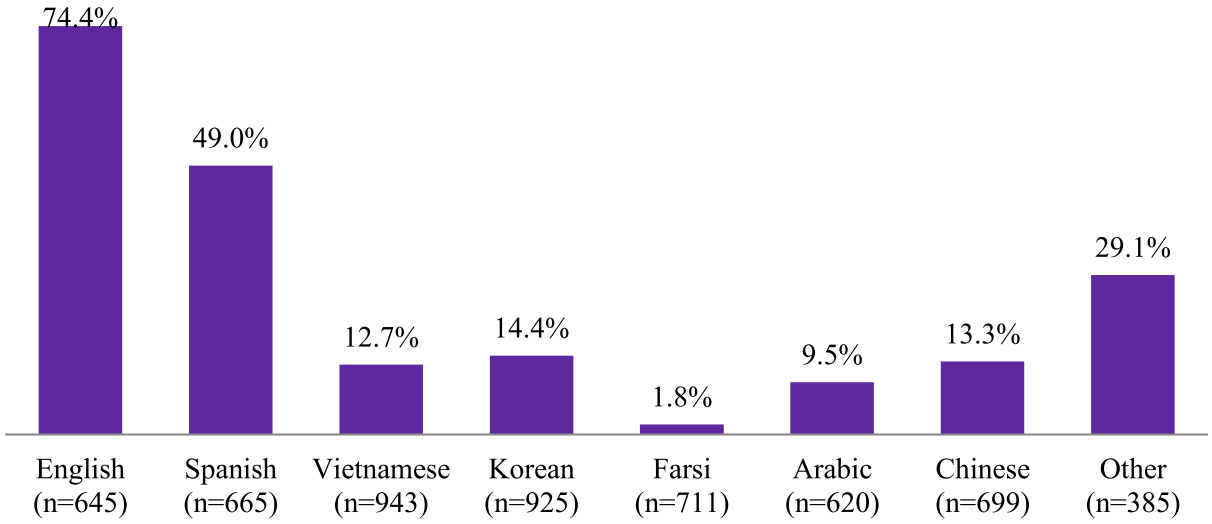
Region:



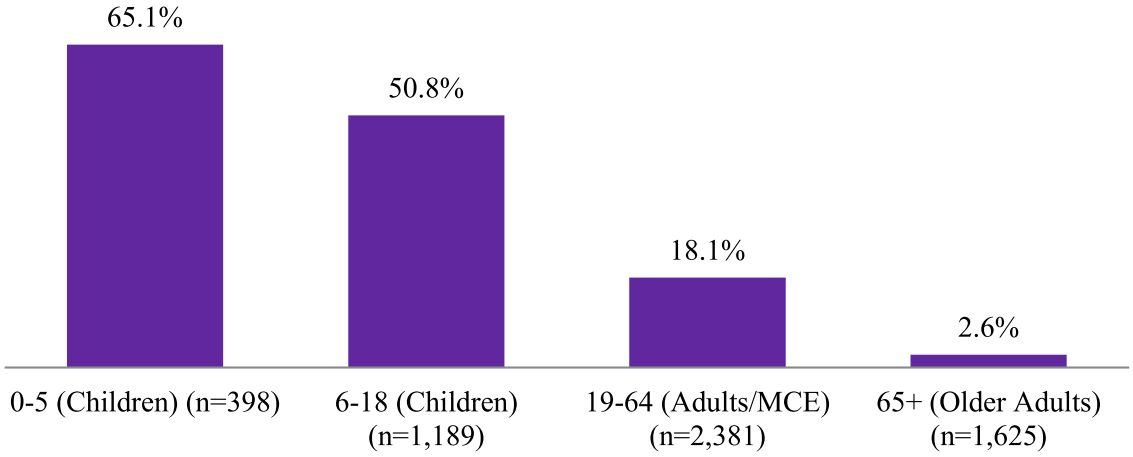
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

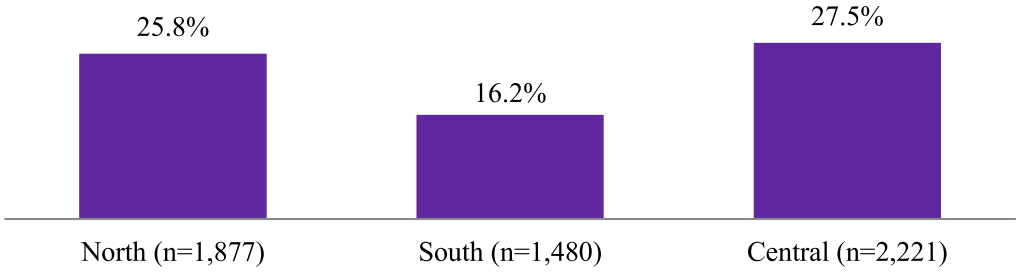
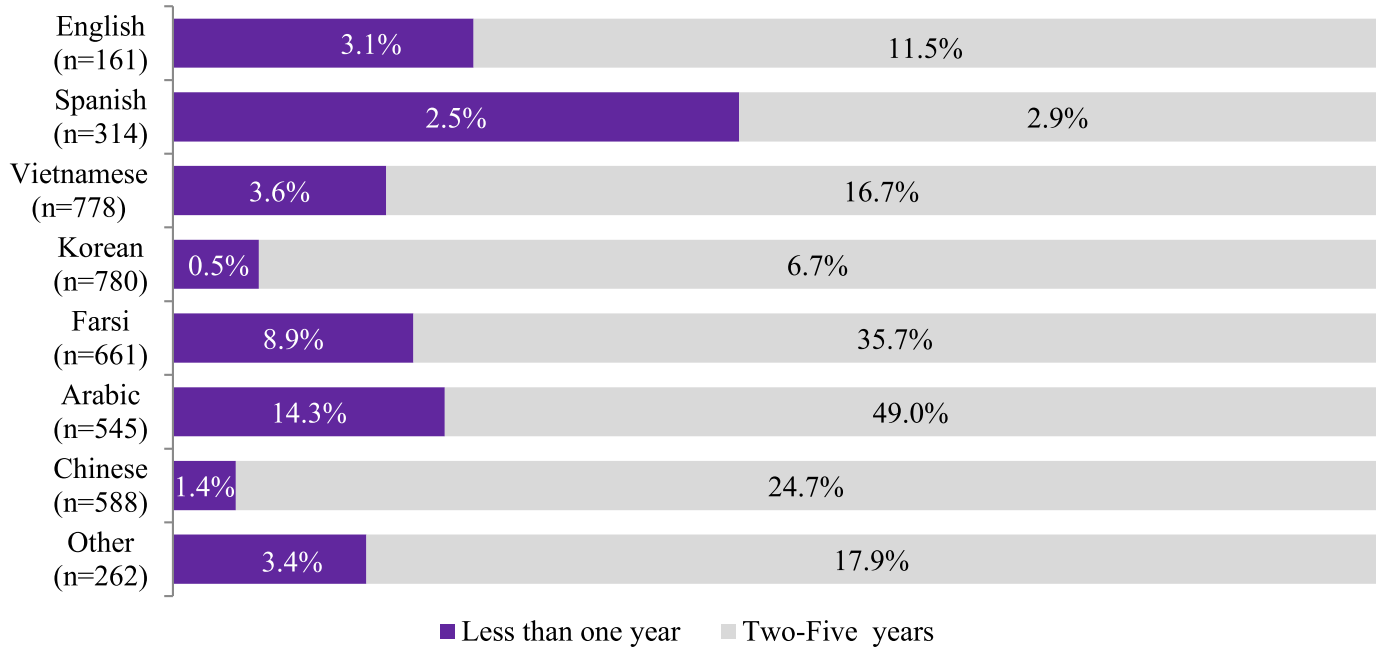
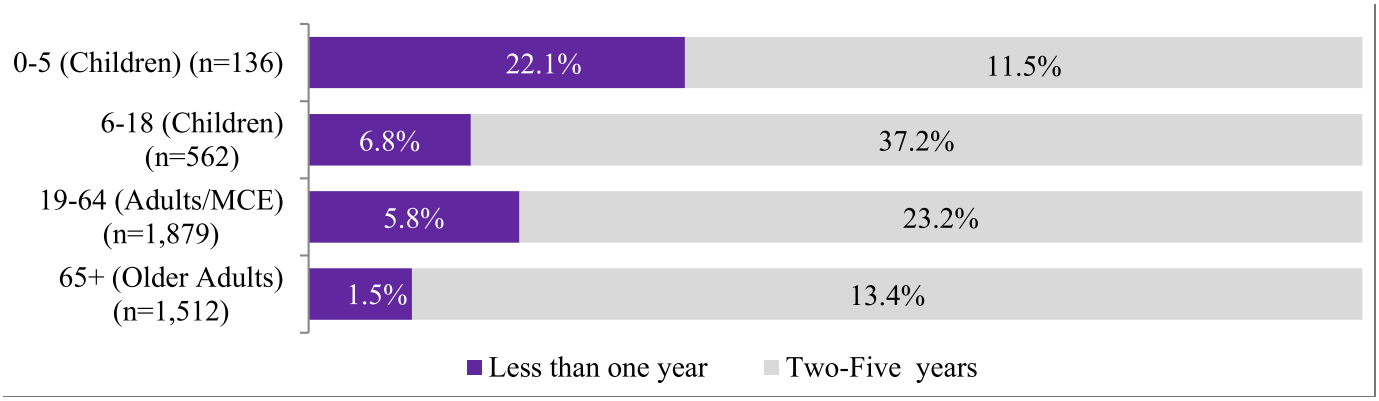


Exhibit 23. Length of time lived in the United States of those not born in the United States

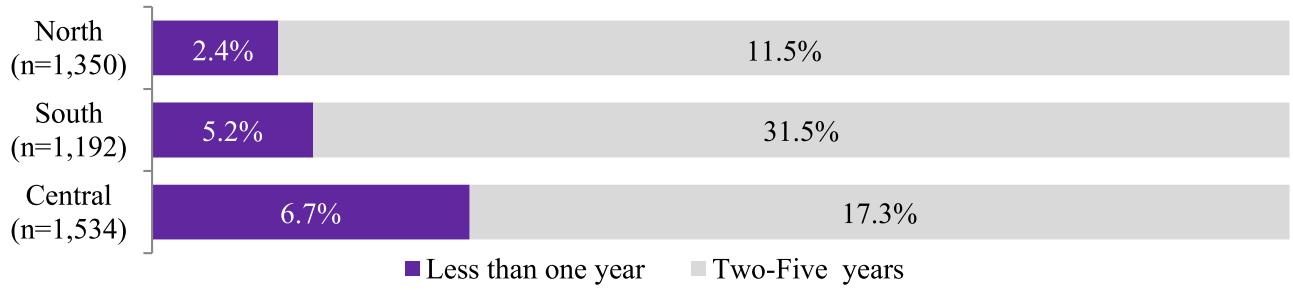
CalOptima language:



Age Category:



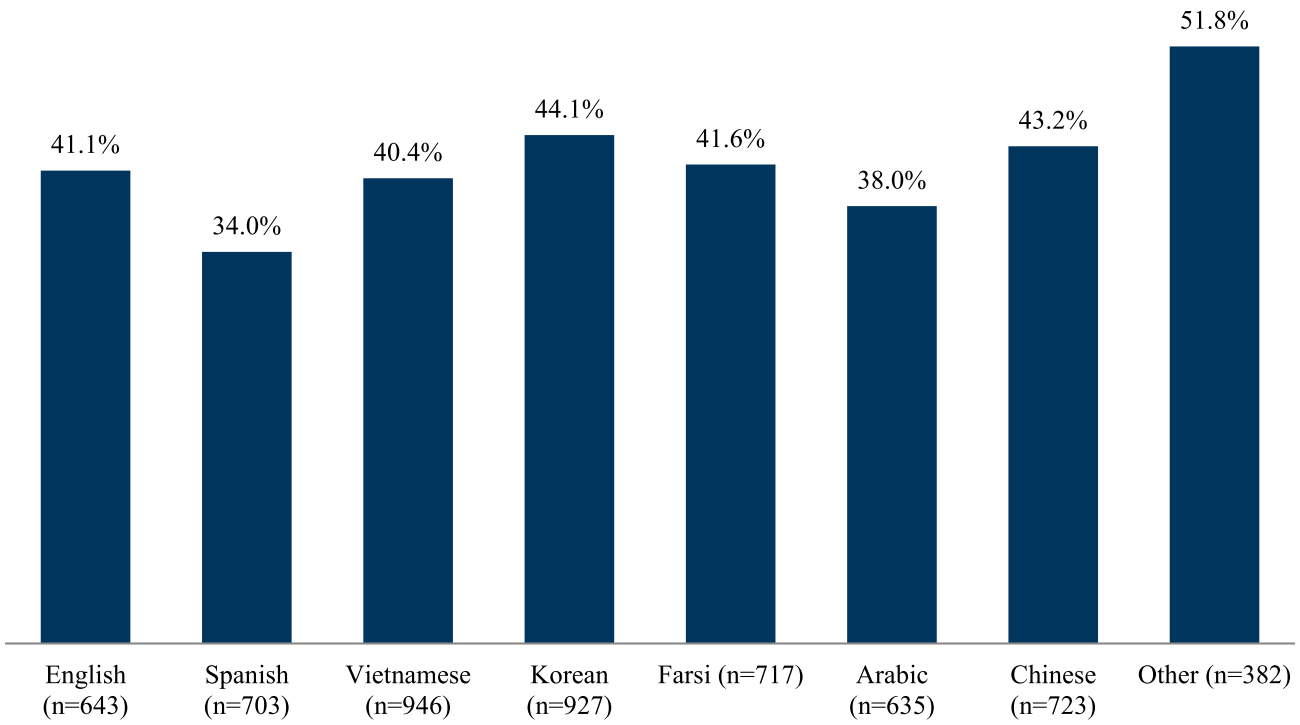
Region:



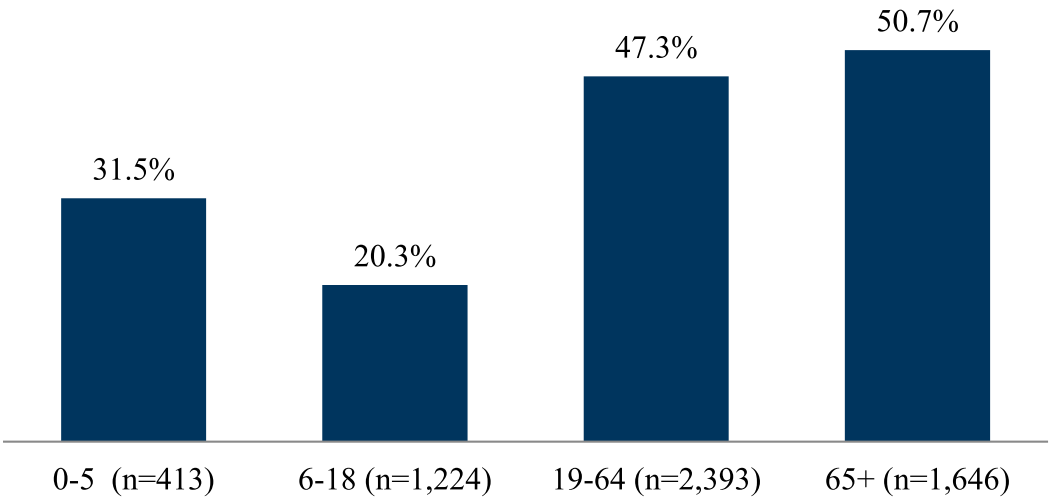
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

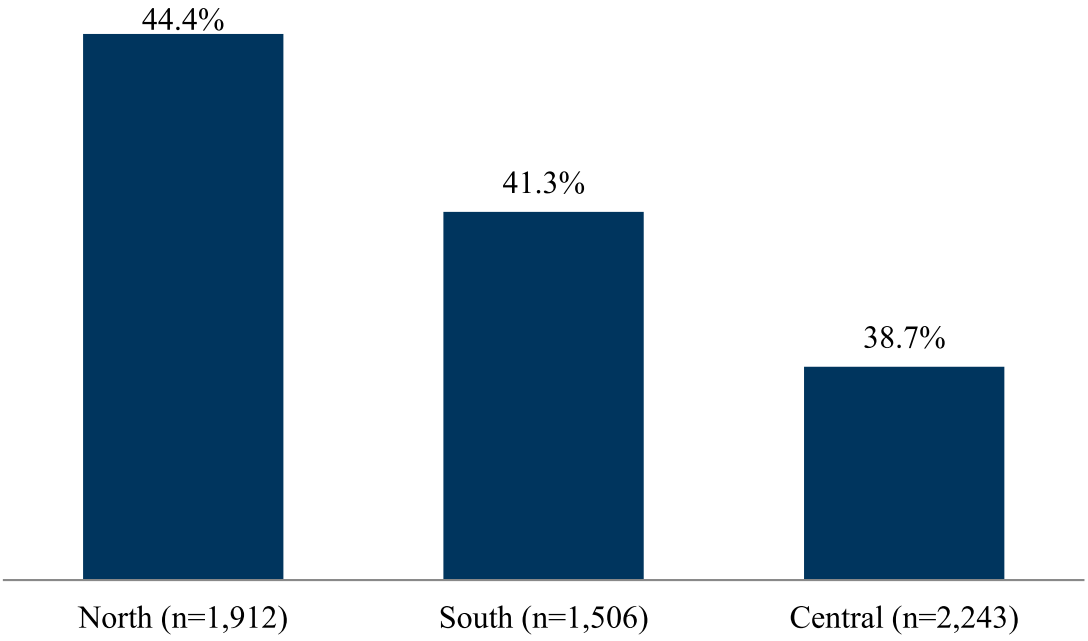


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder + co | community research

CalOptima A Public Agency Better. Together.

Back to Agenda Back to Item

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

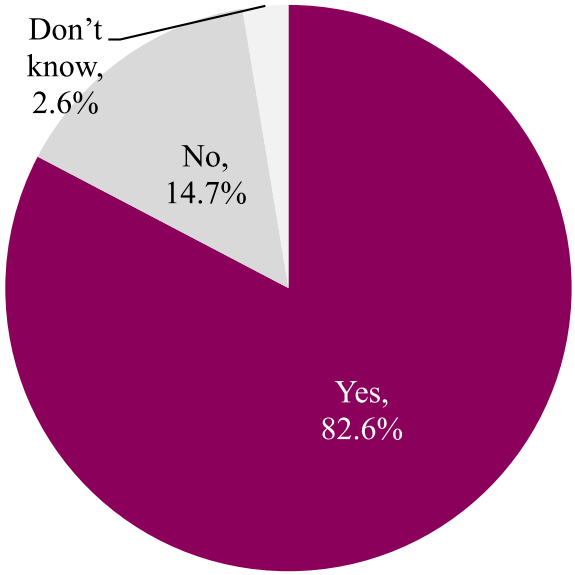


Exhibit 28. Where respondents go to see their doctor (n=5,743)

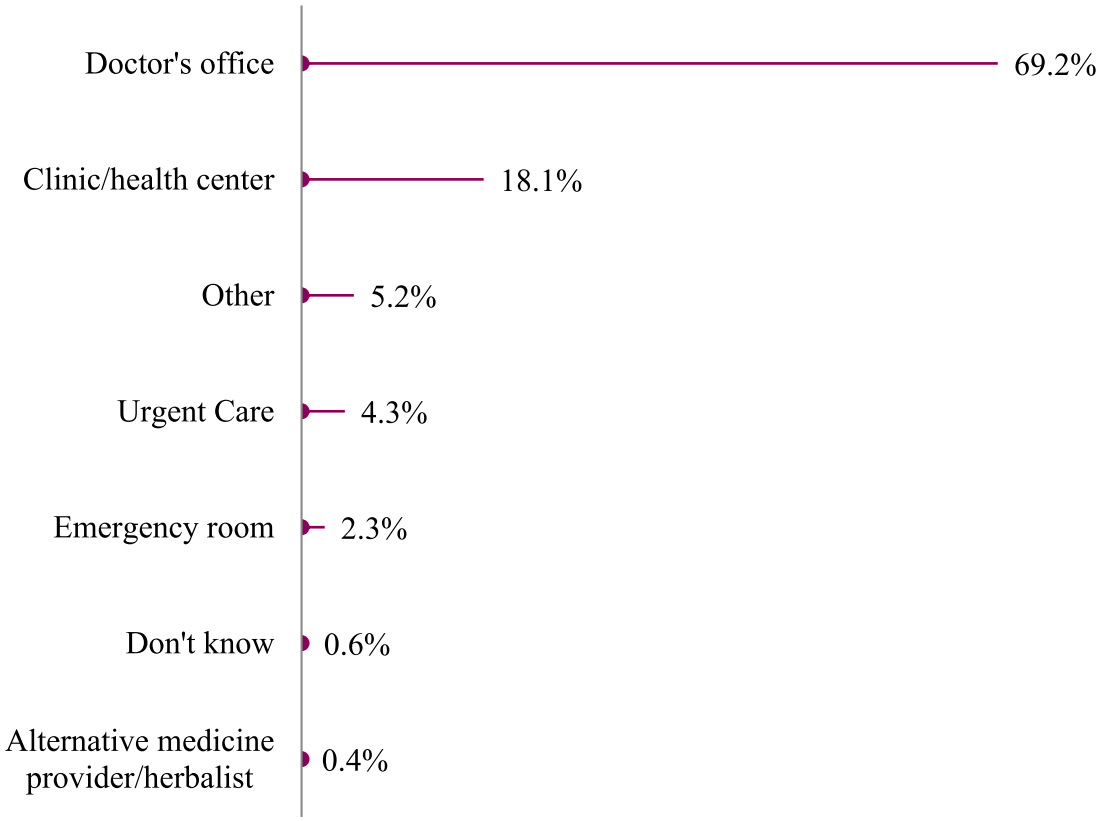


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

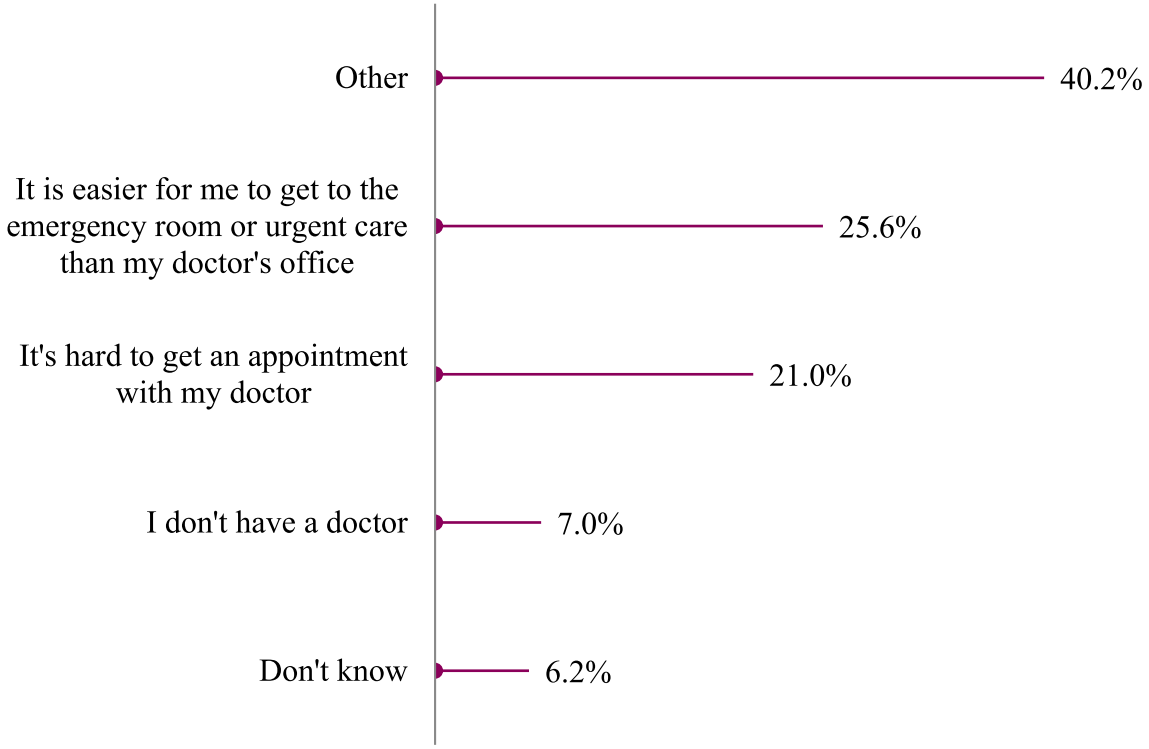


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

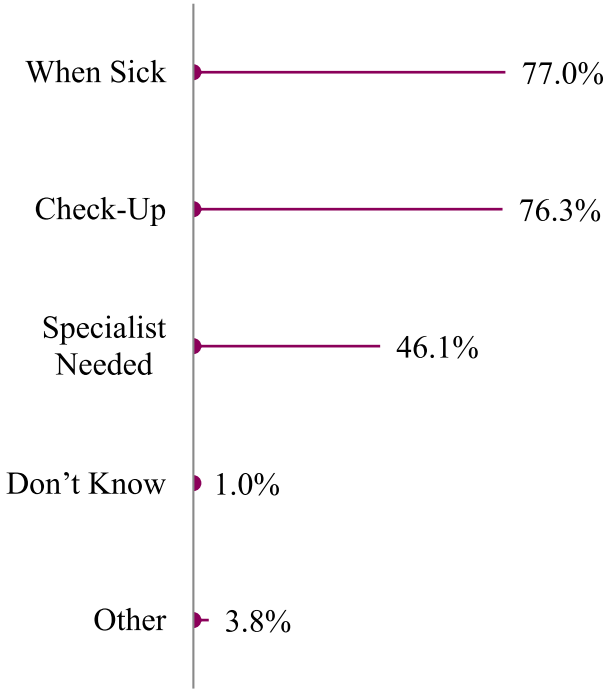
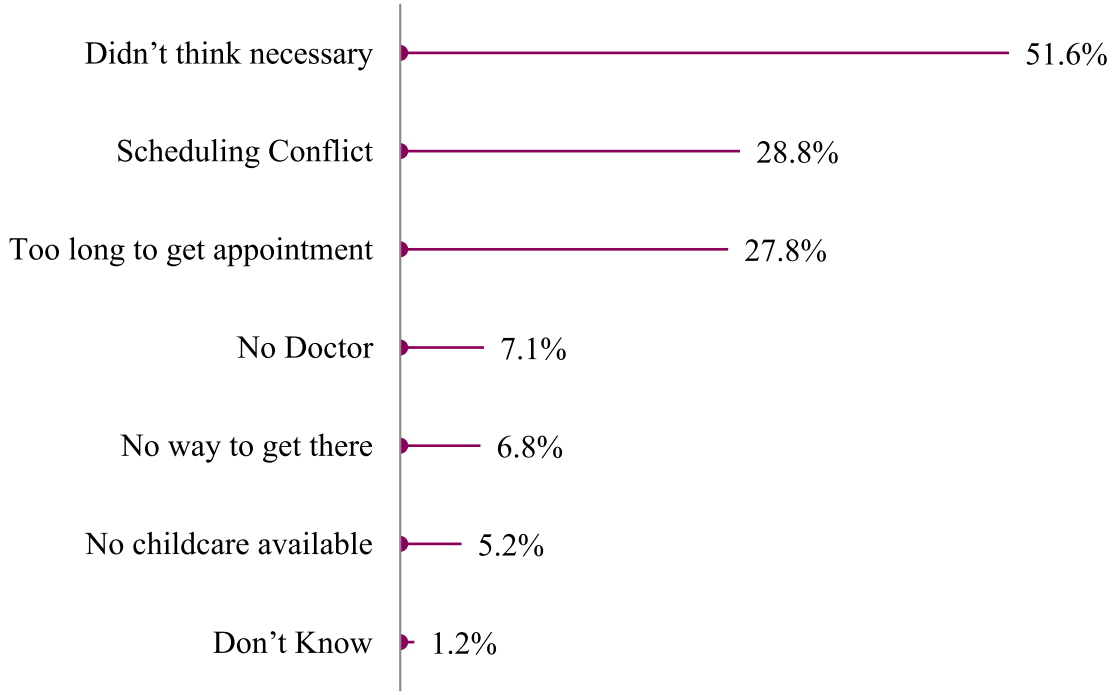


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

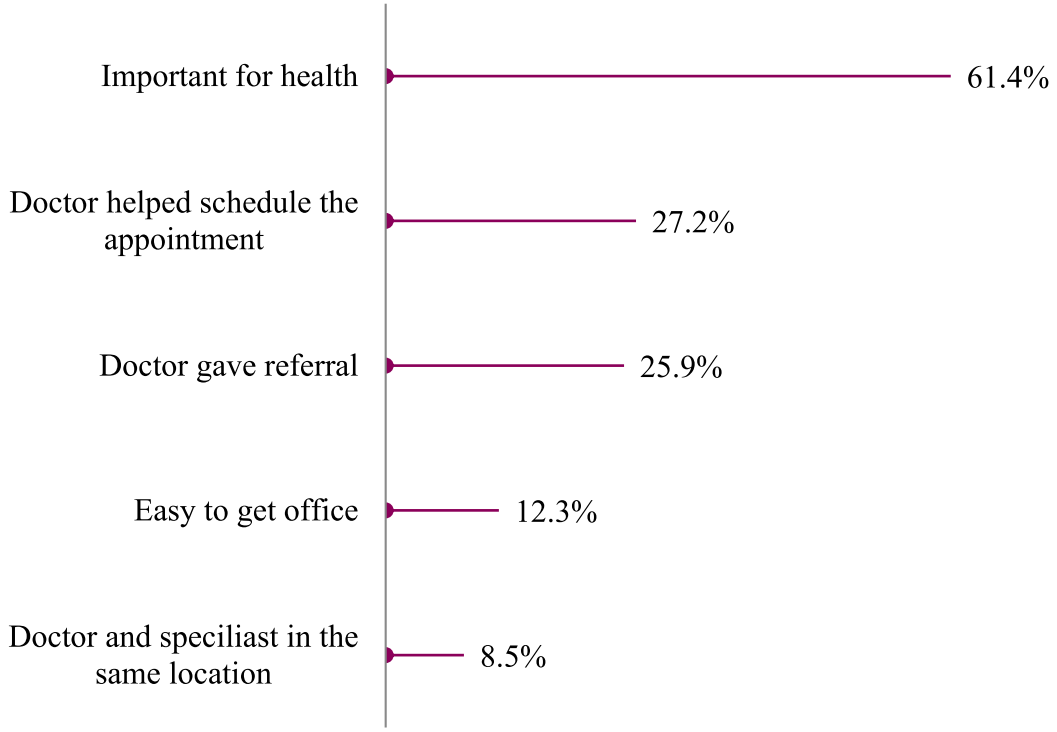
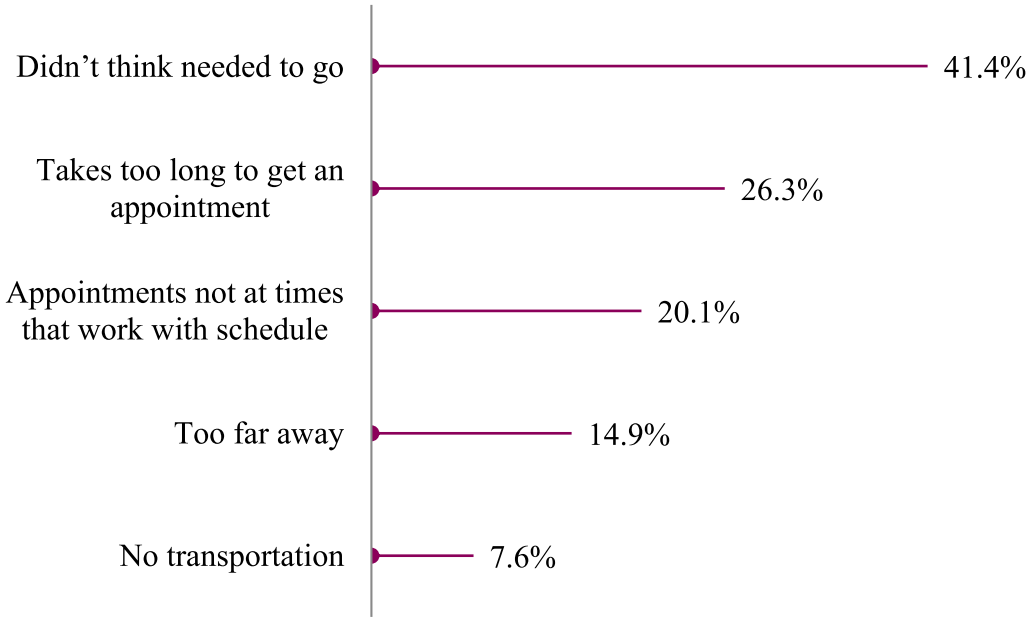
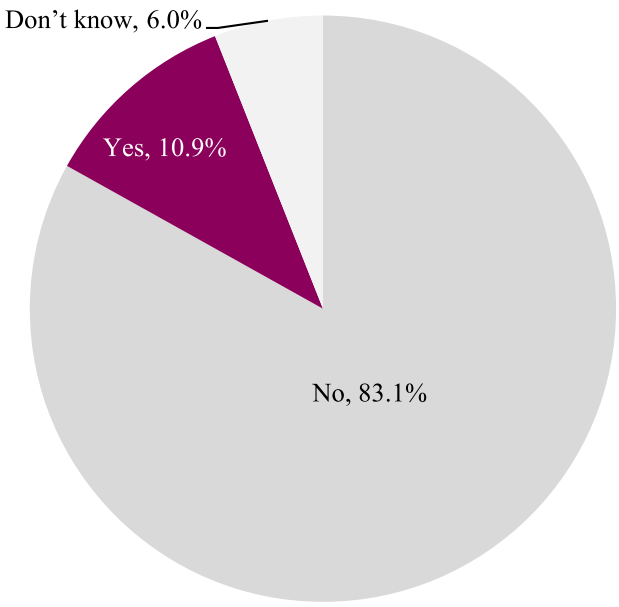


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

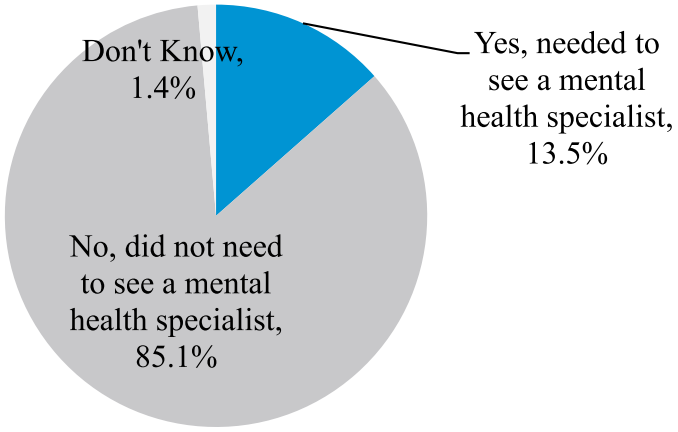


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

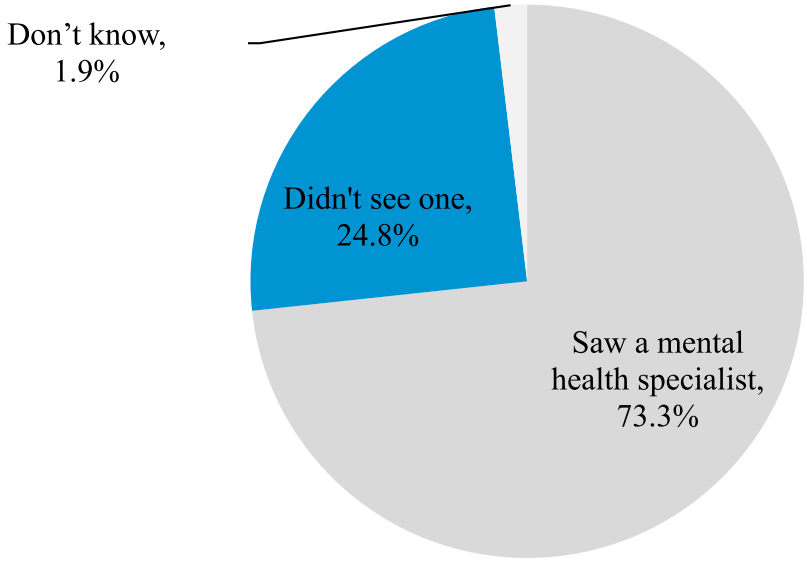


Exhibit 37. Reasons why members didn't see mental health specialist[24]

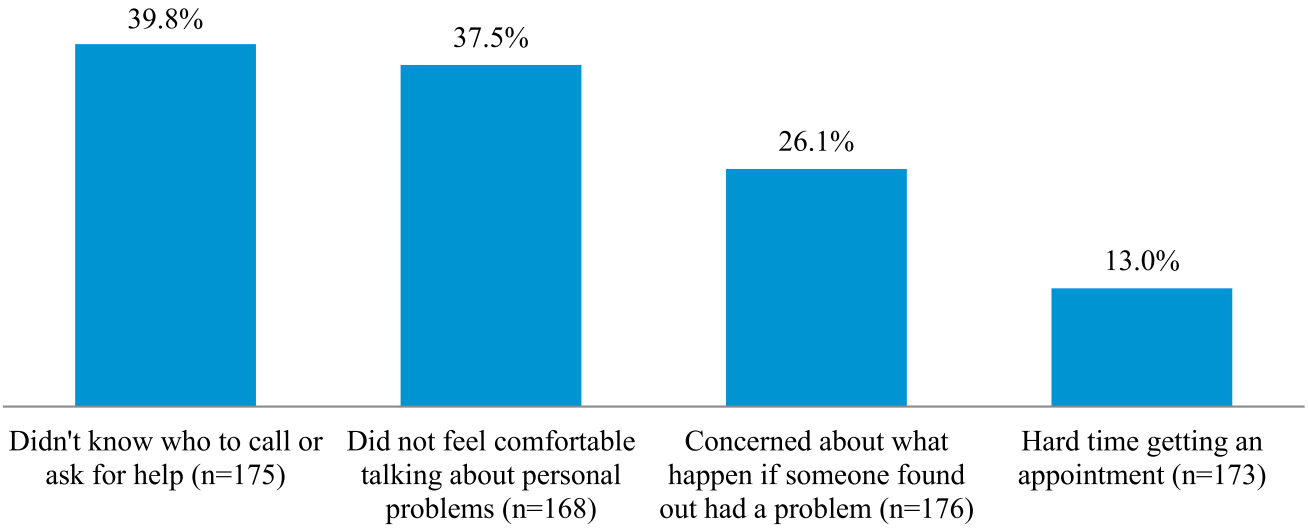
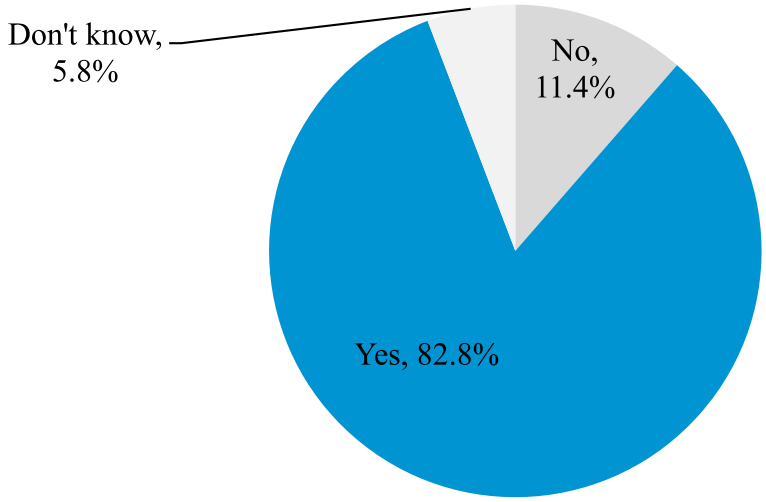


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

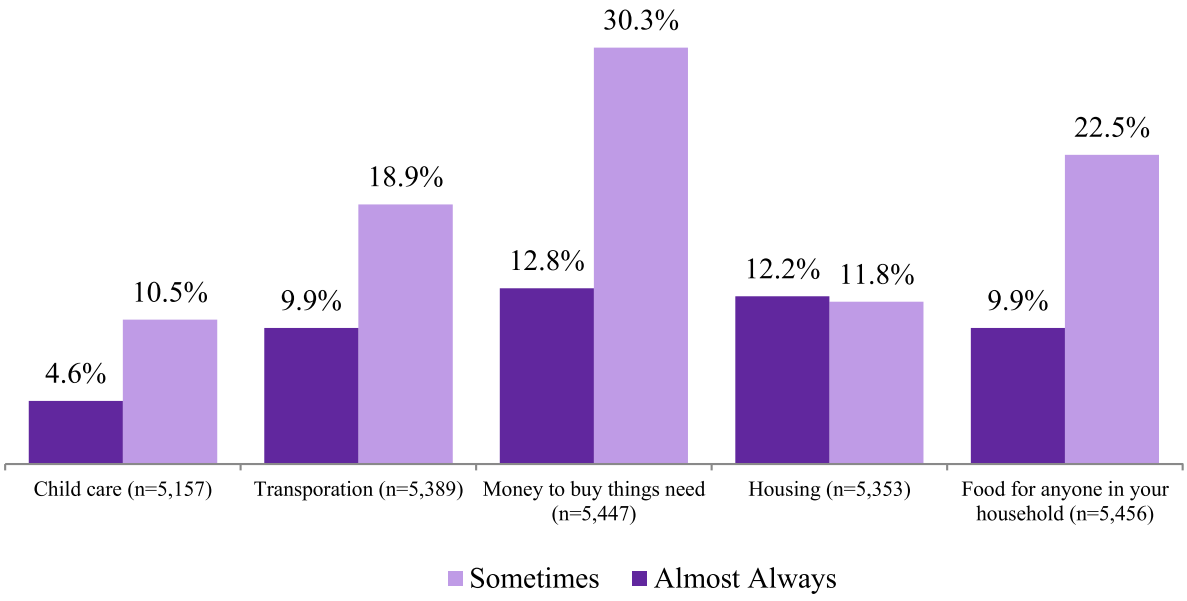


Exhibit 41. Percent of members who receive public benefits (n=5,117):

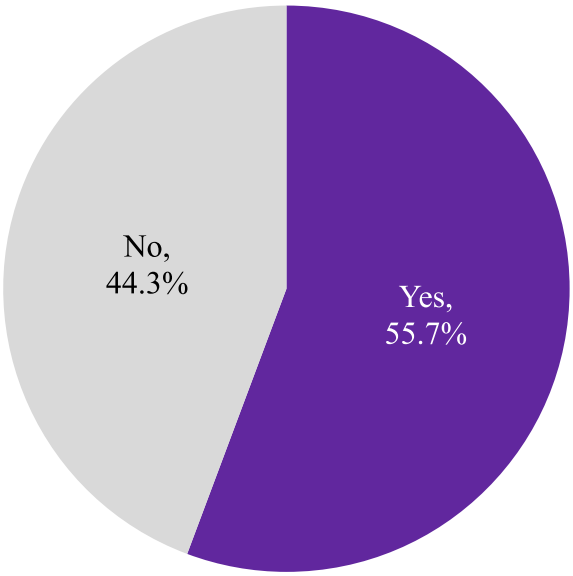
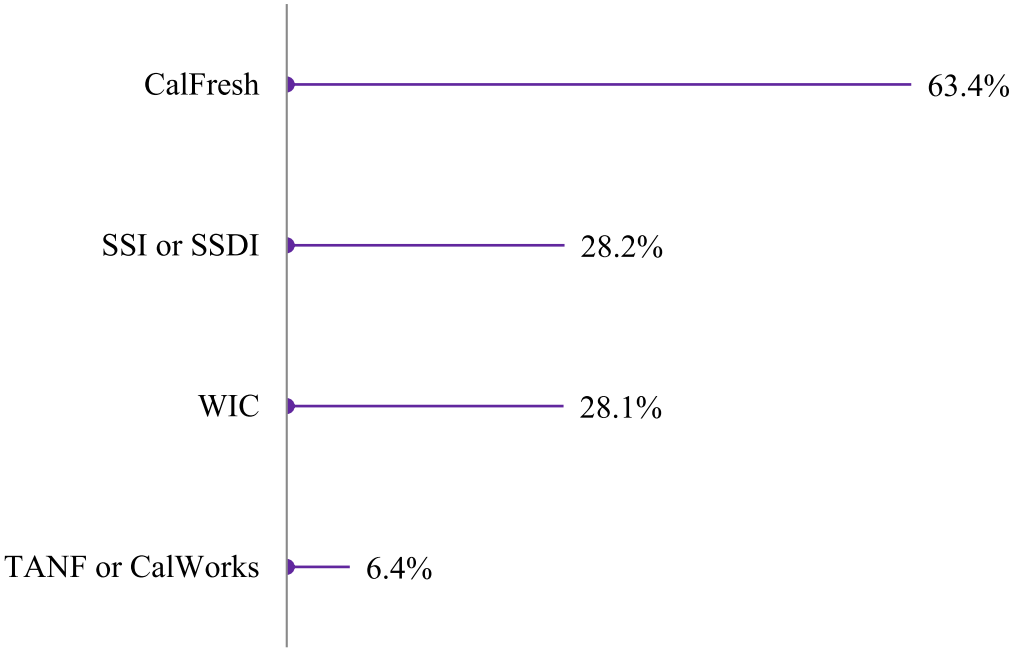


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

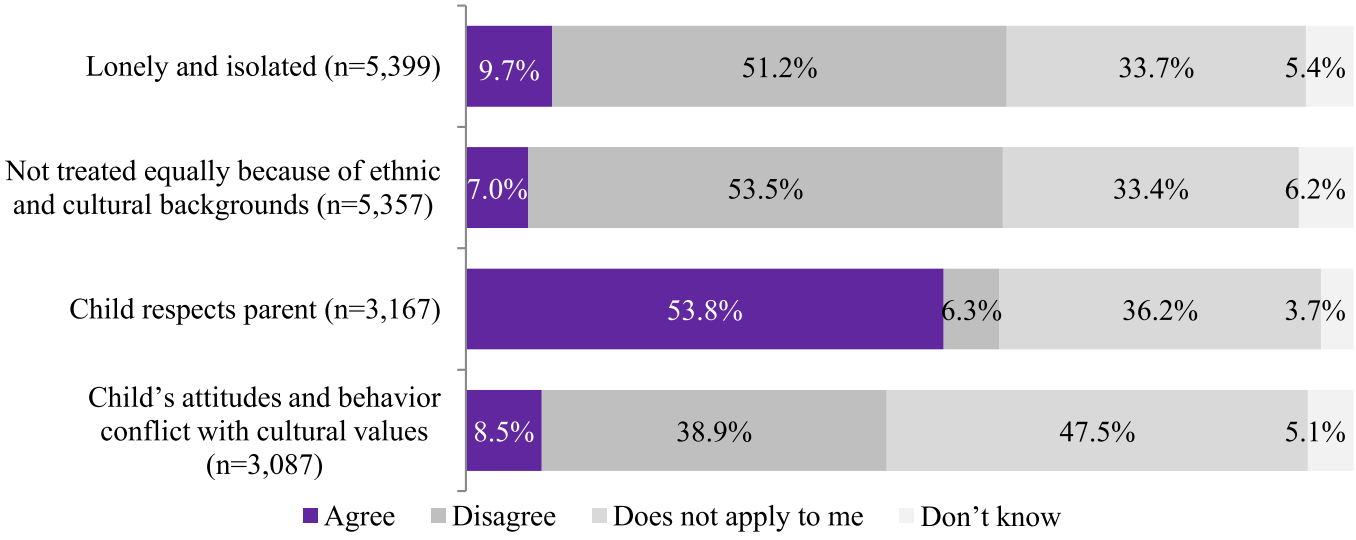


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

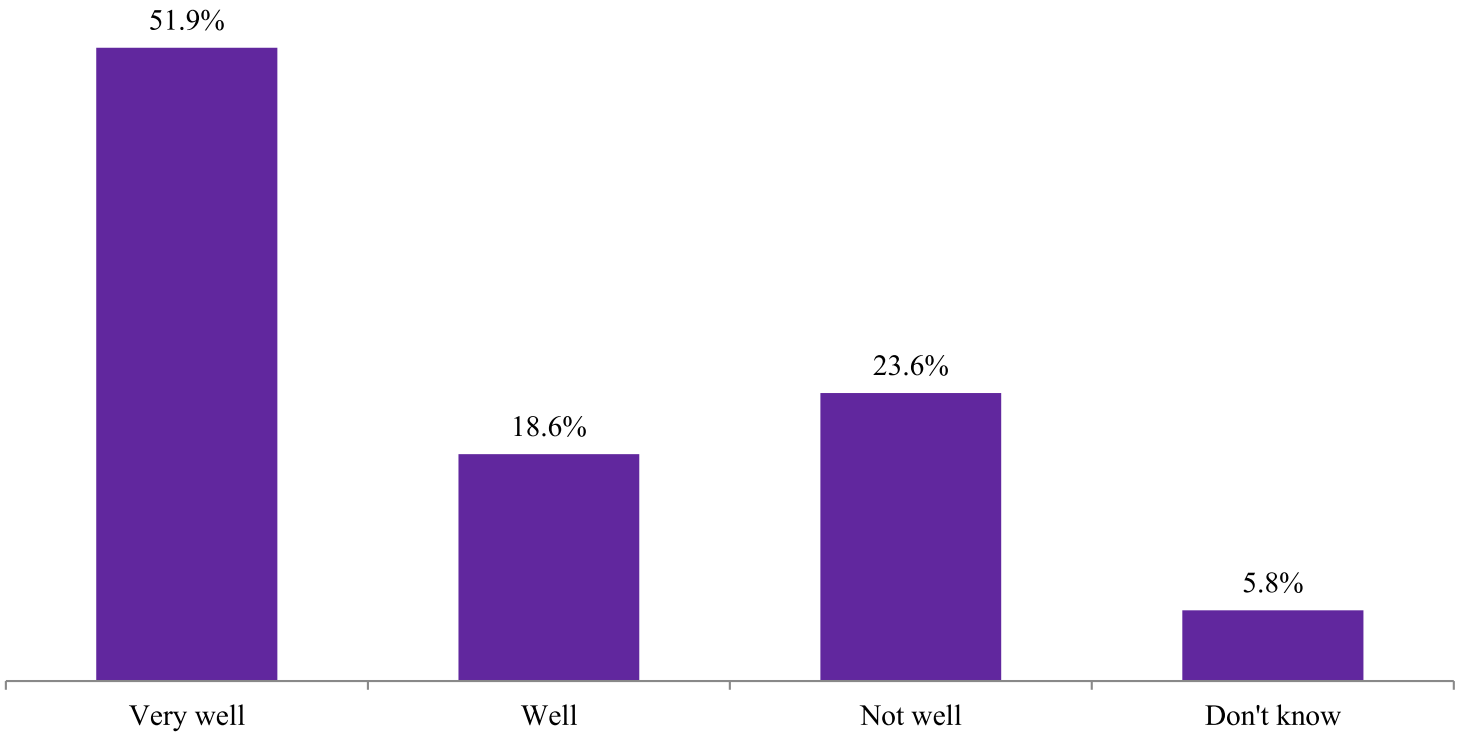


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

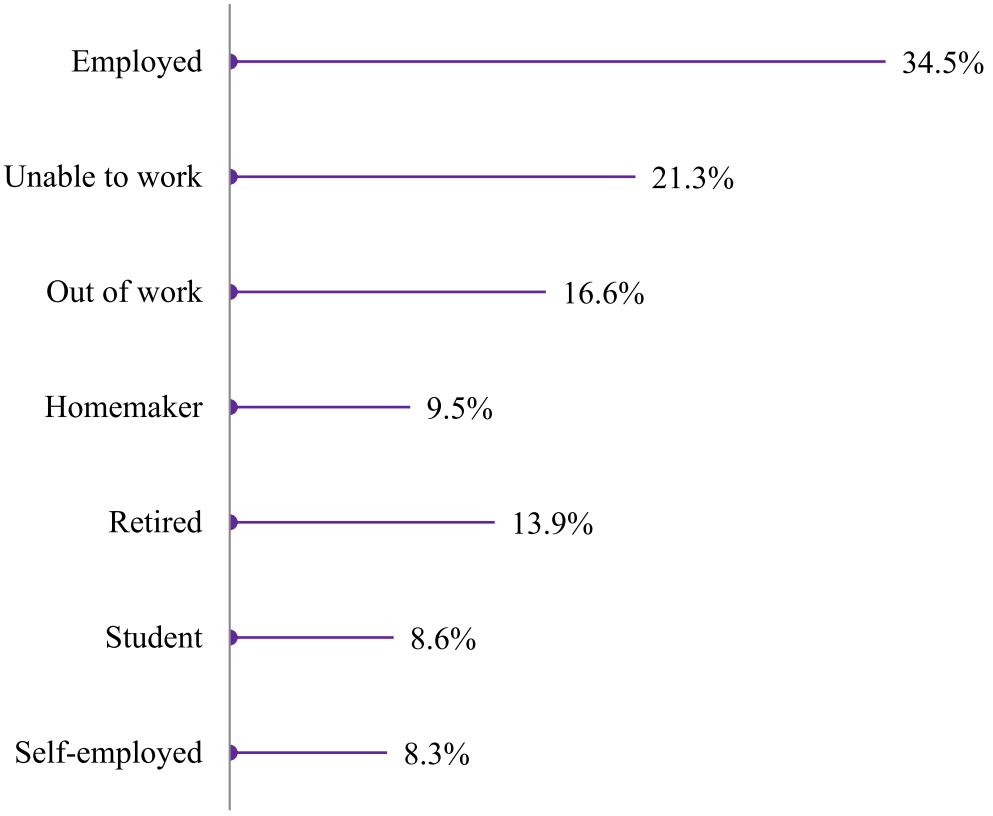
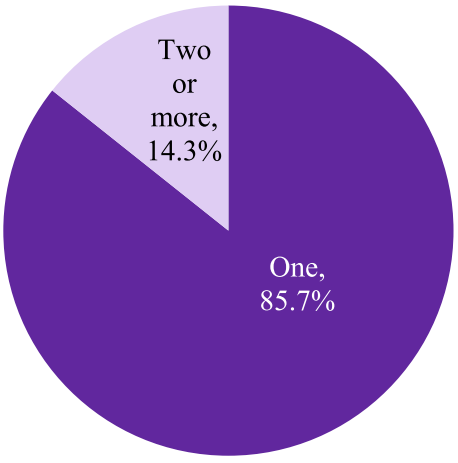
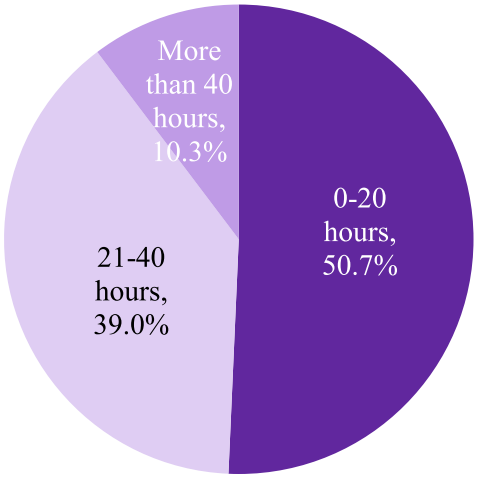


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

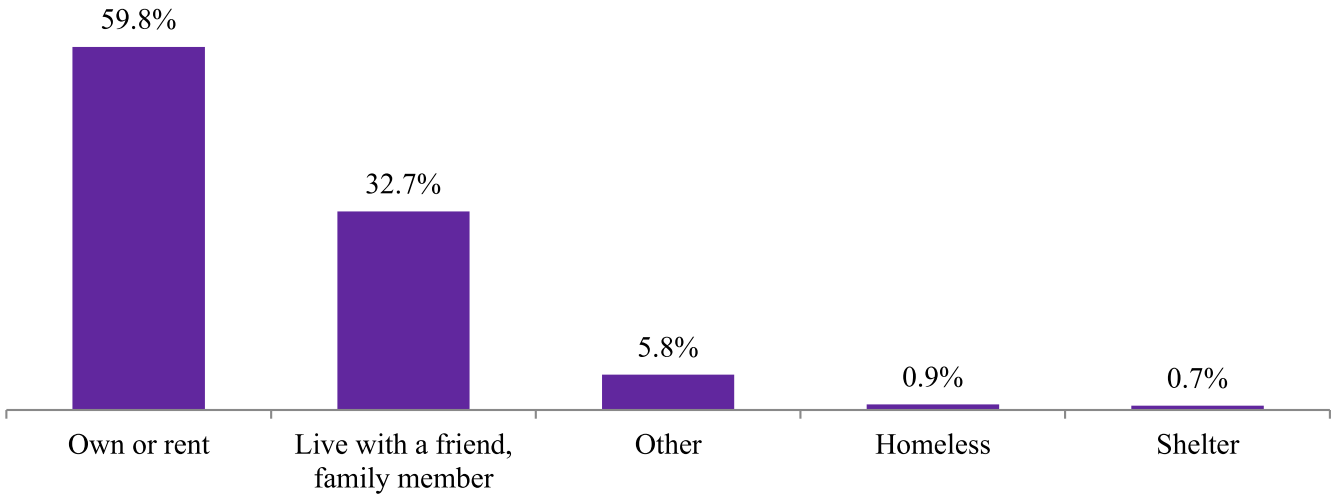
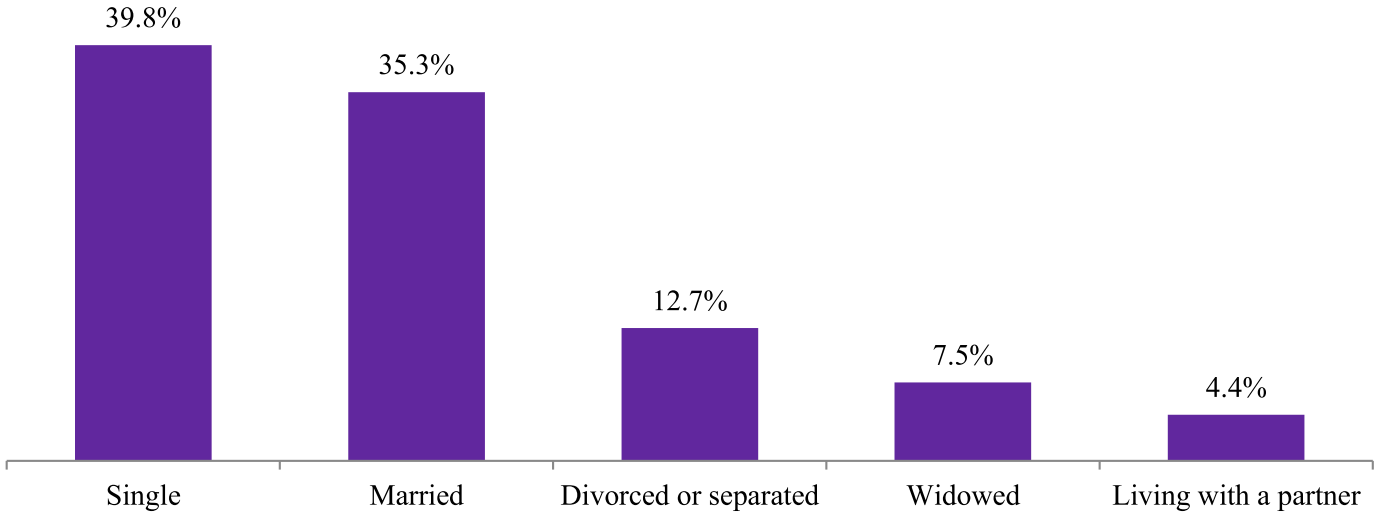


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

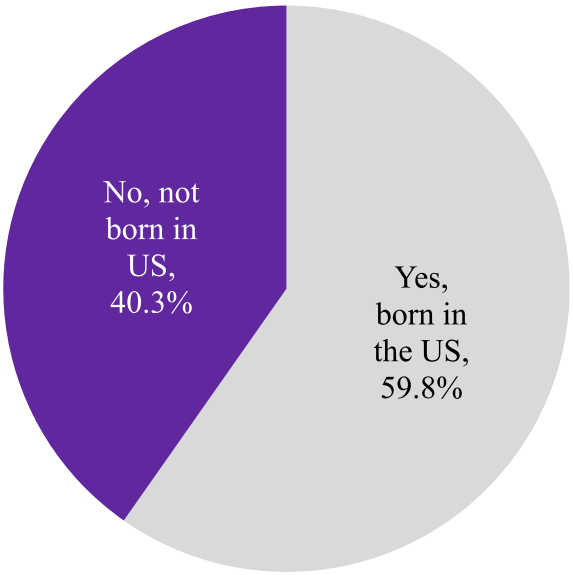
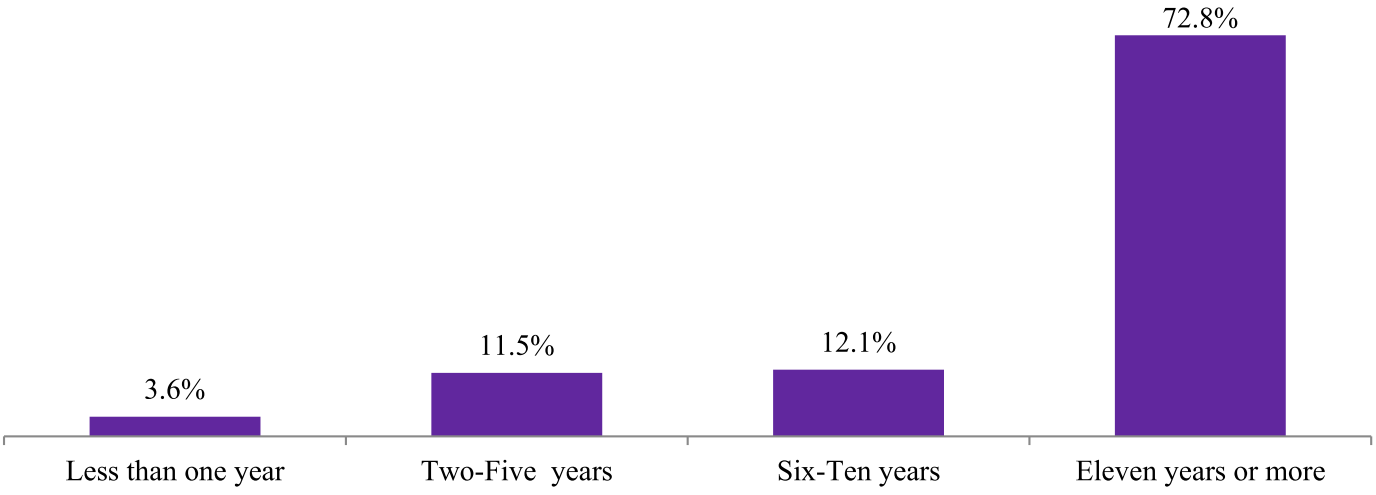


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

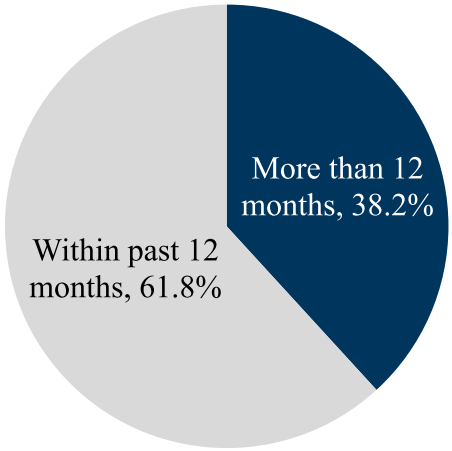
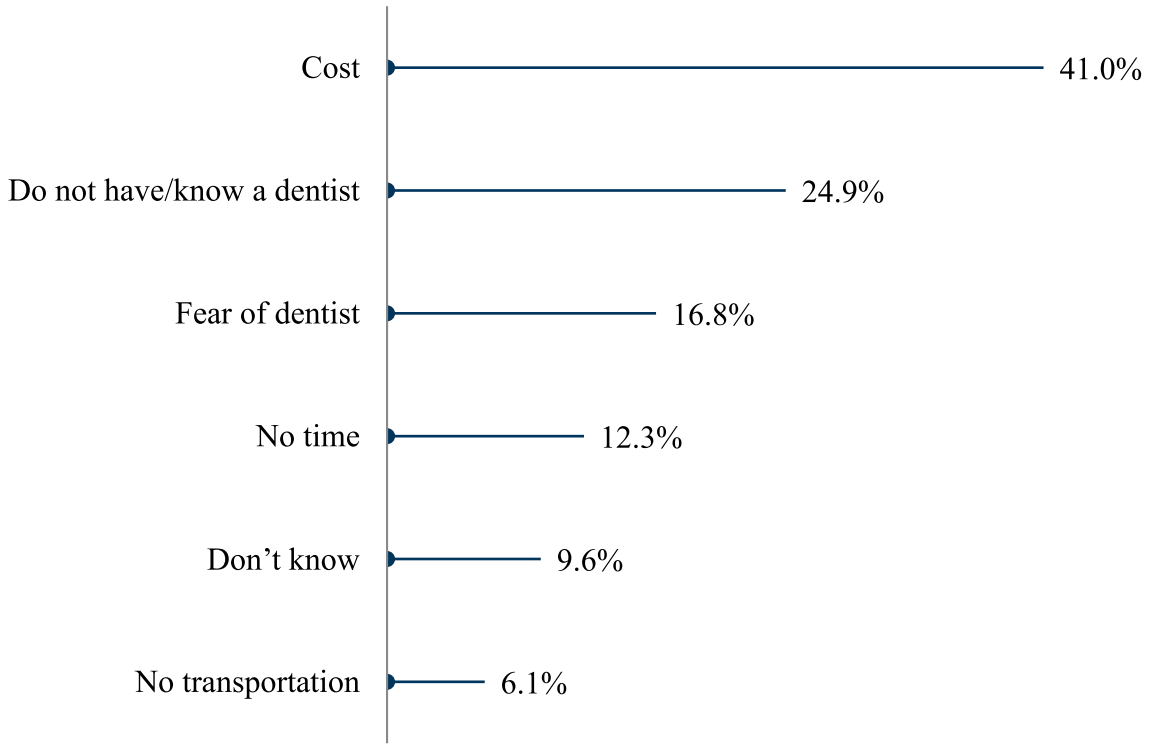
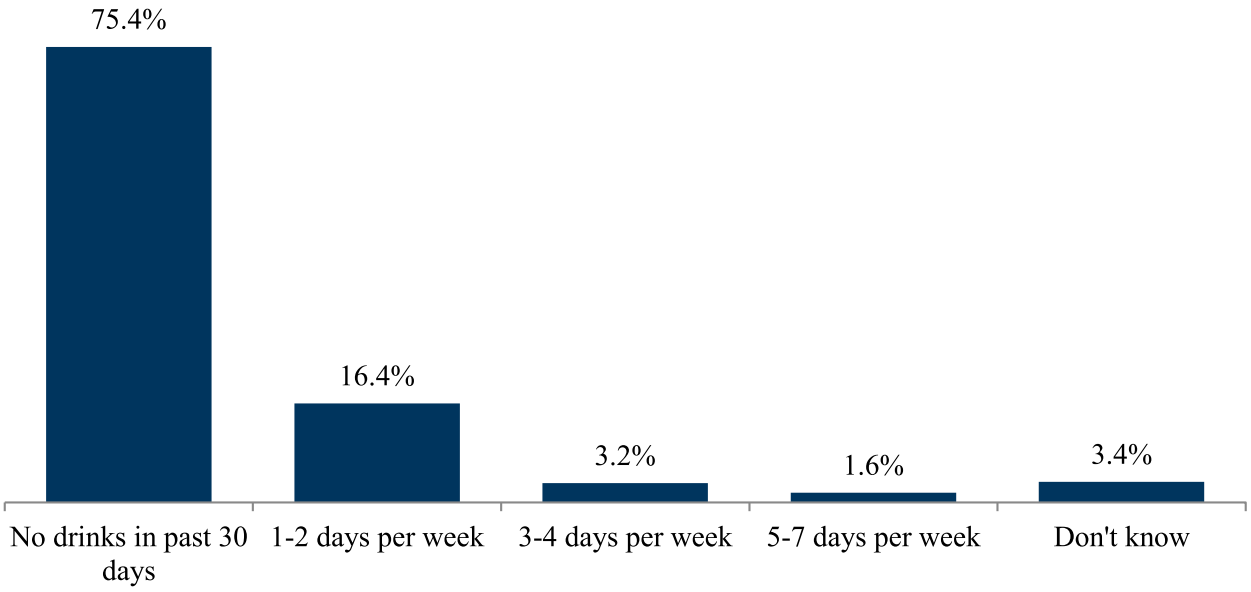


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of 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 IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

Back to Agenda Back to Item

Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

Back to Agenda Back to Item

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal 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. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

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

1/25/2018 — **Date**

Select Pages Redacted

The following Attachments 1-3 to the February 1, 2018 Board Action Request Item 11: *Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization for the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release of Requests for Proposals for Community Grants* are being redacted.

1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary – Member Health Needs Assessment
3. CalOptima Member Survey Data Book

These Attachments are already included above with this September 3, 2020 Board Action Request

Back to Agenda Back to Item

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:

- 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

- 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**

Back to Agenda

Back to Item

Be Well OC Regional Wellness Hub

Board of Directors Meeting

December 6, 2018

Cheryl Meronk

Director, Strategic Development

Mental Health in Orange County

Back to Agenda

- 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

Back to Item

Be Well OC Regional Wellness Hub

Back to Agenda

- 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

Back to Item

Wellness Hub Services May Include:

Back to Agenda

- 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

Back to Item

Be Well OC Regional Wellness Hub

Back to Agenda

- 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

Back to Item

- Estimates are that more than 50% of local Emergency Department visits for mental health and substance use disorder issues are CalOptima members

Anita St. Wellness Hub

Back to Agenda

- 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

Back to Item

Wellness Hub Funding Deliverables

Back to Agenda

- 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

Back to Item

Recommended Actions

Back to Agenda

- 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.

Back to Item

Back to Agenda

Back to Item

Be Well

ORANGE COUNTY

265 ANITA ST. PROPOSAL

Back to Agenda

Back to Item

Back to Agenda

Back to Item

Vision: Be Well Orange County will lead the nation in optimal mental health[1] and wellness for all residents.

Back to Agenda

Back to Item

[1]In the following document, the terms mental health and wellness encompass substance dependence and abuse.

Back to Agenda

Back to Item

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.**

Back to Agenda

Back to Item

Back to Agenda

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.

Back to Item

Back to Agenda

Back to Item

Back to Agenda

Back to Item

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.

Back to Agenda

Back to Item

Back to Agenda

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

Back to Item

Back to Agenda

Back to Item

Back to Agenda

Back to Item

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.

Back to Agenda

Back to Item

Back to Agenda

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%**

Back to Item

Payer Mix	5 Mile Radius Payer Mix %
Medi-Cal	52.9%
Commericial	23.0%
Self Pay	11.4%
Medicare	11.3%
Other	1.4%
Totals:	**100.0%**

Total OC Market	5 Mile Radius of 265 Anita
15,441	5,463
10,772	2,379
3,823	1,176
3,464	1,172
525	147
34,024	**10,336**

Back to Agenda

Back to Item

Back to Item

Back to Agenda

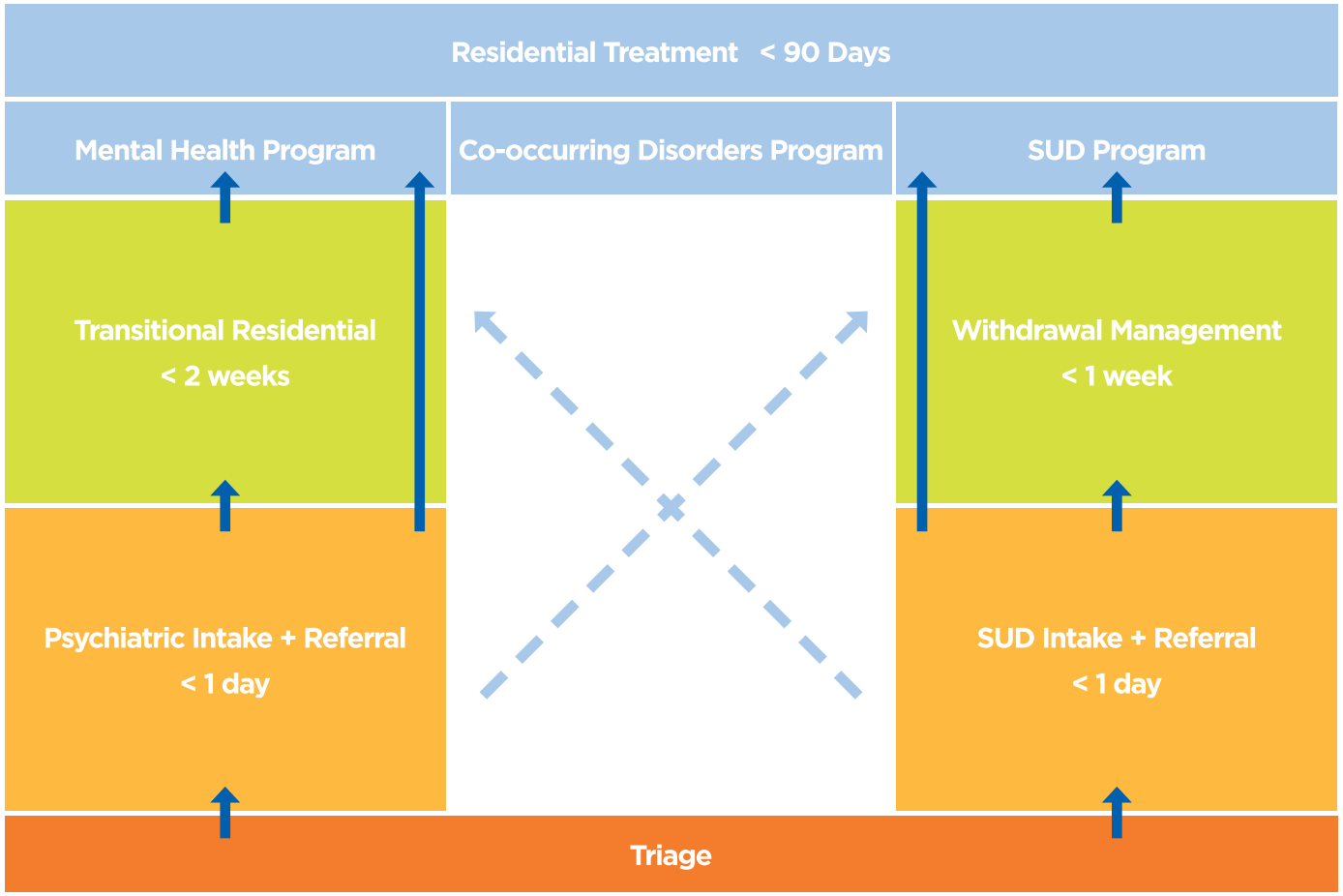
Back to Agenda

Back to Item

Back to Agenda

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.

Back to Item

Back to Agenda

Back to Item

Back to Agenda

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.

Back to Item

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**

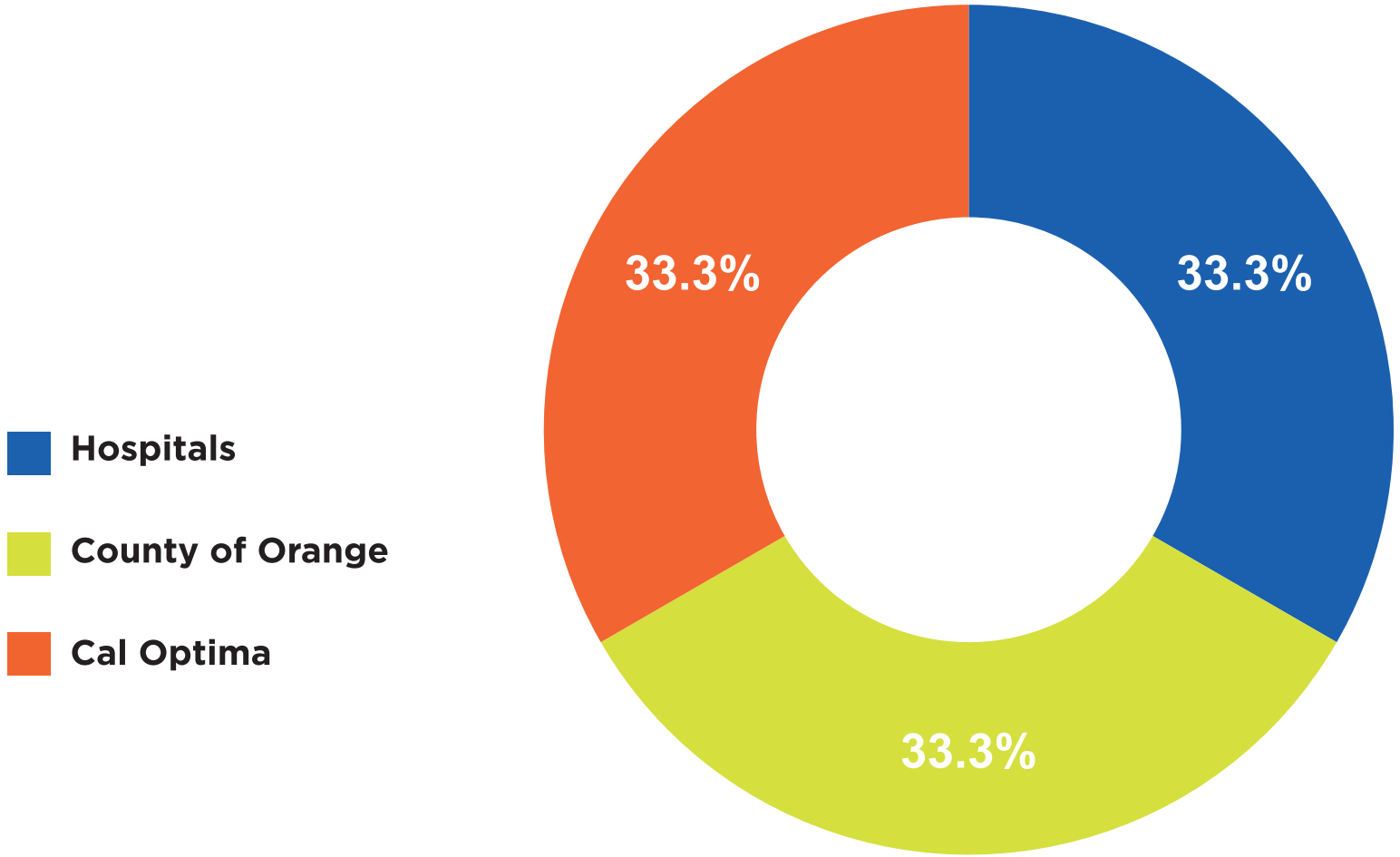
Back to Agenda

Back to Agenda

Financing Model

Syndicated Prorata Share

Back to Item



Back to Agenda

Back to Item

Back to Item

Back to Agenda

Back to Agenda

Back to Item

Back to Agenda

Back to Item

Be Well

ORANGE COUNTY

Back to Agenda

Back to Item

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:

Back to Agenda Back to Item

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**

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**

Back to Agenda Back to Item

Back to Agenda

Back to Item

Community Grant RFP Recommendations

Board of Directors Meeting

December 6, 2018

Cheryl Meronk

Director, Strategic Development

Back to Agenda

Back to Item

IGT 5 Process Summary to Date

Back to Agenda

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

Back to Item

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

IGT 5 Expenditure Process

Back to Agenda

- 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

Back to Item

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

Grant Funding

Back to Agenda

- **$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**

Back to Item

Three Recommended Grant RFPs

Back to Agenda

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**

Back to Item

* Multiple awardees may be selected per RFP

RFP 1

Back to Agenda

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

Back to Item

RFP 2

Back to Agenda

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

Back to Item

RFP 3

Back to Agenda

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

Back to Item

Next Steps*

Back to Agenda

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

Back to Item

* Dates are subject to change based on Board approval

RFP 1. Access to Children's Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 156,064	Expansion of Portable Oral Health Services and Tele-dentistry in Orange County	Expand access to portable Oral Health Unit services through addition of a Dental Hygienist and introduce a tele-dentistry component into the program.	600
Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	Provide a dental home with a mobile dental unit equipped to provide pediatric preventive and restorative treatment, thereby completing the circle of dental care. This project will enable five federally qualified health centers (FQHC) and FQHC Look-Alikes to establish a dental home with regular and emergency care for children and families	9,000
Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	Provide preventive (screenings, dental cleanings, fluoride, sealants) and restorative treatment (fillings and cavity treatment) to CalOptima children at schools, primary care clinics, and community sites. Children who require advanced restorative treatment (such as treatment under general anesthesia) will be referred to traditional clinics in Garden Grove and CHOC Children's Hospital.	13,564
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Children	Educate members on optimal dental health by creating a strong traditional and social media presence. Provide exams and screenings to students in a mobile dental vehicle.	1,000

Back to Agenda Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Children in North Orange County	Develop a mobile dental care program in conjunction with the school districts and schools to do full dental exams, take x-rays, place sealants, and address problems such as dental caries.	1,310

RFP 2. Primary Care Services & Social Determinats of Health

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
CHOC Children's	$ 1,396,813	The School-based Student Wellness Center: Addressing the Social Determinants of Health Where Children Are	Create three School-based Student Wellness Centers within three Orange County school districts and enhance current mental health OC Department of Education (OCDE) offerings with novel physical health and social determinant services led by a school site Coordinator and staffed by medical, nutrition, fitness, and social services personnel.	3,886
Coalition of Orange County Community Health Centers	$ 1,400,000	Healthy Kids, Healthy Schools	Collaborate with five schools in establishing school-based wellness centers throughout Orange County. These wellness centers will provide immunizations, health screenings, health education, and direct comprehensive health care (medical, dental, vision, and behavioral health) with community clinics. Six letters of support from schools/school districts were submitted.	5,500

Back to Agenda Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
NAMI Orange County	$ 174,794	Decreasing Stigma Through Mental Health Education, While Increasing Access to Wellness Resources	NAMI-OC will host Ending the Silence (ETS) presentations and conduct outreach at schools to further educate and increase awareness surrounding mental health conditions. Resource Navigation services will also be offered for students and their families.	13,590
Santa Ana Unified School District	$ 1,400,000	Family and Community Engagement (FACE) Wellness Centers	Enhance the Family and Community Engagement (FACE) Wellness Centers at all 57 K-12 school sites across the school district. Service providers, healthcare professionals, and local clinics will conduct services within the centers which are located within walking distance from the homes of families and residents of the entire Santa Ana community. SAUSD collaborates with local stakeholders; business organizations, institutions of higher learning, for-profit and nonprofit organizations in order to provide wrap-around services for students, families and the surrounding community. Several agreements have already been established with service providers to partner with the SAUSD.	50,000

Back to Agenda Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Serving Kids Hope	$ 1,351,412	School-Based Wellness Program	The project formalizes district-wide wellness assessment based on State Wellness Standards, establishing baseline and measurement of impact. It will be data-driven, with district-wide wellness assessment, documented services, and analysis and reporting of outcomes. Two letters of support from school districts were submitted.	25,975
Wellness & Prevention Center	$ 224,631	Expansion and Integration of South Orange County School-Based Wellness Centers into the CalOptima Primary Care Network	Expand five school-based wellness centers and leverage existing agreement with the Capistrano United School District. Project will increase bilingual staff, expand parental engagement, and create educational materials.	300

RFP 3. Access to Adult Dental Service

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 150,678	Expanded Access to Adult Dental Services in Orange County	Expand access through the addition of a dental team in the Santa Ana clinic location and expand service hours (evening and weekend). The project also: increases awareness about coverage; promotes timely treatment plan completion; links members to a dental home; and integrates culturally-responsive, language-appropriate dental and medical services.	300

Back to Agenda Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Camino Health Center	$ 50,000	Adult Dental Services Expansion	Camino Health Center will be using funds to provide additional evening and weekend hours in the current dental clinic. The additional hours will allow more patients in the community access to receive dental services with hours that may be more compatible to their personal schedules. The additional funding for elective dental procedures with lab fees will allow patients to have access to procedures not covered by insurances.	150
Families Together of Orange County	$ 1,000,000	Bridging the Gap: Addressing Orange County's Oral Health Needs	Open a new health center with four dental exam rooms located on the border of Garden Grove and Anaheim, targeting patients who speak Arabic, Spanish, or Vietnamese. Dental care will be integrated into FTOC's comprehensive primary care services with evening and weekend hours.	6,000
KCS Health Center (Korean Community Services)	$ 987,600	Integration of MECCA Community Based Organizations with FQHC Adult Oral Care Access in Mobile and Nontraditional Delivery Modalities	KCS Health Center requests to build mobile sites at each of its six (6) partnering MECCA community-based organizations and extend hours of operation to nontraditional hours at the mobile sites as well as at KCS Health Center and Southland Integrated Services locations. The organizations together serve populations that speak Spanish, Vietnamese, Korean, Farsi, Arabic, and Khmer	8,000

Back to Agenda Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Adults	Educate members on optimal dental health by creating a strong traditional and social media presence. Add an additional day (on Fridays) for 9 hours to provide more access to care and allow more appointments.	1,000
Livingstone Community Development Corporation	$ 350,000	Finding Your Smile: Expanding Dental Services for Adults Beyond Emergency Care	Expand direct preventive and restorative dental services by increasing dental program staff, extending hours and days of operation and providing improved integration with its primary care program. The dental program will provide exams and x-rays, dental cleaning, cavity fillings, extractions, root canal treatments, and crowns.	2,500
Serve the People	$ 1,000,000	Oral Health for the Homeless	Establish dental care access points with a three-chair dental mobile unit at 10 homeless shelters managed by homeless support service providers. These new dental homes will provide preventative, restorative, and specialized dental care to CalOptima members.	1,500
St. Jeanne de Lestonnac Free Clinic	$ 180,000	Oral Health Program	Increase outreach efforts and purchase equipment and supplies to treat more patients. Dental services include exams, x-rays, fillings, root canals, and tooth extractions. Lab work and/or dental prosthetics will be available to patients at cost with no additional markup.	100

Back to Agenda Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Adults in North Orange County	Develop a mobile dental care program serving adults in La Habra to do full dental exams, x-rays, sealants, and addressing problems such as dental caries. The program will be include an outreach initiative, to helping to raise awareness of safety-net healthcare services, and promoting knowledge of and access to CalOptima's health care services.	1,426

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 3, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards a Community Grant(s) for Access to Children's Dental Services

Contact

Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions

1. Award IGT 5 funds in the amount of up to ~~$1 million~~ $500,000 to Coalition of Orange County Community Health Centers and up to $500,000 to Healthy Smiles for Kids of Orange County ~~for a~~ for community ~~grant(s)~~ grants for Access to Children's Dental Services; and
2. Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant ~~contract(s)~~ contracts with the selected community ~~grantee(s)~~ grantees.

Rev. 10/3/19

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At its April 7, 2016 meeting, the CalOptima Board of Directors approved priority areas for IGT 5 to guide CalOptima's community support, including the priority area "Strengthening the Safety Net." To gain greater awareness of the unique healthcare needs of CalOptima members, the Board authorized staff to contract with a vendor to conduct a Member Health Needs Assessment in December 2016. The health needs assessment was completed in February 2018, and in June 2018, the Board authorized release of eight Requests for Information (RFI) to help inform development of scopes of work for Requests for Proposals (RFP) under IGT 5, including an RFP related to Children's Dental Services. In July 2018, 93 RFI responses were received. At its December 6, 2018 meeting, the Board approved a prepayment of $11.4 million for services to be provided to CalOptima members at the Be Well Wellness Hub, and the release of three RFPs, including one involving up to $1 million to support Access to Children's Dental Services within the Strengthening the Safety Net priority area.

Five responses to the Access to Children's Dental Services RFP were received, and an external subject matter expert and staff evaluated and scored the responses. These results were shared with the IGT 5 Board Ad Hoc Committee comprised of Vice Chair Khatibi and Director Nguyen. On July 23, 2019, this Ad Hoc Committee met to consider the RFP responses. Following the review of the evaluation results and the site visit comments, the Ad Hoc Committee recommended that $1 million be awarded to Healthy Smiles for Kids of Orange County. On August 1, 2019, the Board considered the Ad Hoc Committee's recommendation and deferred action, directing staff to return to the full Board with additional information. The item was then agendized and subsequently continued from the agenda for the September 5, 2019 Board meeting.

Back to Agenda Back to Item

Discussion

During the August 1, 2019 meeting, the Board directed staff to provide additional information on the RFP development and evaluation process, as well as the findings of the evaluation and final scores of the proposals submitted in response to the Access to Children's Dental Services RFP.

RFP Development

The Access to Children's Dental Services Scope of Work (attached) was based on responses to the RFIs received in July 2018 and required applicants to address the following topics in their proposals:

- 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 services in addition to exams and screenings as needed; and,
- Include integration with medical care for early childhood through referral for well-check visits.

RFP Evaluation Process

The RFP evaluations were based on an Evaluation Matrix (attached) including the weighted categories below:

- Organization Information (10%)
- Project Information (55%)
  - Statement of Need (5%)
  - Project Description (20%)
  - Evidence Supporting Approach (5%)
  - Outreach and Education (10%)
  - Sustainability Plan (5%)
  - Population Served (10%)
- Project Staffing (10%)
- Project Budget (10%)
- Work Plan information (15%)

Listed below are the two highest rated RFP responders along with their scores based on evaluation of their respective written RFP responses.

	Evaluation Criteria										
	Organization	Statement	Description	Evidence	Outreach	Sustainability	Population	Staffing	Budget	Workplan	Grand Total
Coalition of Orange County Community Health Centers											
Score	15	15	15	14	15	14	14	13	15	15	145
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.5	0.75	3	0.7	1.5	0.7	1.4	1.3	1.5	2.25	4.87
Healthy Smiles for Kids of Orange County											
Score	14	15	14	13	13	11	15	15	14	14	138
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.4	0.75	2.8	0.65	1.3	0.55	1.5	1.5	1.4	2.1	4.65

Some highlights from their applications are summarized below.

	Coalition of Orange County Community Health Centers (Coalition)	Healthy Smiles for Kids of Orange County (Healthy Smiles)
Title	Mouths Matter: Establishing a Dental Home for All Children	Full Cycle Dentistry
Requested Amount	$1 million	$1 million
Score	4.87	4.65
Description	• Will establish a new mobile unit to be shared by five community health clinics ○ Families Together of Orange County, Korean Community Services, North Orange County Regional Health Foundation, Serve the People, and Southland Integrated Services • Adds a new provider for dental services, as one of these clinics does not provide dental services	• Enhances four mobile units and a mini clinic to ramp-up restorative care (e.g., staff, equipment, supplies, outreach and engagement materials) • Will increase access to preventive and restorative care • Have provided dental services to children in Orange County through clinics and school-based programs since 2003 • Expects to collaborate with 11 school districts

	○ The other four clinics provide pediatric dental services at their fixed sites • Expects to collaborate with six school districts	
Use of Funds (examples)	• Purchase and equipping mobile unit • Consulting (coordinating with clinics for HRSA change in scope/licensing and curriculum development) • Staff • Supplies (e.g., dental, oral hygiene kits)	• Restorative and portable equipment expansion • Recruitment and training for 20 new clinical positions, as well as portion (less than 20%) salary and other costs • Service fees (contract reviews and move costs for mini clinic) • Supplies for mobile units, mini clinic, staff, outreach materials
Term and Population Served	• During the three-year term: Will serve additional 9,000 CalOptima members ○ First year focusing on infrastructure development (e.g., acquisition of three chair mobile unit, staffing, etc. ○ Services delivery begins in Year 2	• During the one-year term: Will serve 13,500 additional CalOptima members ○ Impact begins immediately upon funding with service delivery begins within three-months

After the evaluations of the written RFP responses were scored and discussed by the RFP review team, site visits were conducted by staff with the top two scoring RFP responders. During the site visits, the applicants had the opportunity to respond to additional questions and share further details on their submitted proposals. Areas for discussion include the following:

- The RFP responding organization's understanding of the project and impact, as well as consistency to its mission and fit with current services provided;
- The RFP responder's leadership capacity and skills to effectively provide the proposed services and address foreseeable challenges;
- Whether services may be duplicative or complementary of those provided by others and opportunities for collaboration; and,
- Any other concerns with, or benefits of awarding, a grant to the organization.

Following the site visit with the Coalition of Orange County Community Clinics, it was noted that the collaborating clinics are very passionate about their work; in addition to the required build out of the mobile unit itself, one of the clinics did not have a dental practice within its fixed site to leverage and, thus, would have to establish a dental practice. Additionally, the grant program implementation was not

entirely clear. Following the site visit with Healthy Smiles for Kids of Orange County, it was noted that the grant would augment an existing program within an established organizational structure; the presentation demonstrated that project goals and objectives were well understood. RFP responses were not rescored after the site visits.

Request for Proposal Evaluation Process – Ad Hoc Review

The IGT 5 Board Ad Hoc discussed the two highest scoring written proposals: Coalition of Orange County Community Health Centers and Healthy Smiles for Kids of Orange County, and considered information from the written proposals, scoring results and site visits. Both organizations submitted strong proposals, with the Coalition being more focused on acquisition of a mobile unit, services and outreach, and Healthy Smiles being more focused on enhancing the current delivery system by ramping up of mobile restorative services e.g., through acquisition of restorative equipment, portable equipment and supplies, and recruitment of new clinicians.

Information considered by the Ad Hoc Committee included whether the respective proposed approaches would expand an established program or add a new program, ramp-up time for services to start and completion time, access and outreach through school districts and other community partners, and new members expected to be served during and beyond the term of the grant.

The Ad Hoc Committee also considered options to split the grant award. At the Ad Hoc's direction, Staff reached out to the two organizations with the highest scoring applications to obtain their feedback related to use of funds if 100% of their proposed grant funding amounts were not awarded, and if they were instead offered 75%, 50%, or 25% of their proposed funding levels. Based on feedback from these two applicants, splitting the amount did not appear to be a viable option. Subsequently, based on the Board's direction, staff again reached out to the applicants following the August 1, 2019 Board meeting to ask them to confirm their ability to accept a smaller grant award amount. Each applicant expressed scalability:

- *Coalition of Orange County Community Clinics*: Two clinics participating in the collaborative have recently acquired additional funding commitment to support purchase and equipping two three-chair mobile clinics. As a result, the initial proposed funding amount could be significantly reduced, ramp up time would be reduced to five months, with the Coalition still achieving the deliverables included in its RFP response (e.g., number of schools engaged, outreach conducted, members served).

- *Healthy Smiles for Kids of Orange County:* In the event the award amount is reduced, the number of children served would be reduced proportionately, for example, 50% award, half of the 13,500 children would be served, while otherwise meeting all deliverables. Services would begin immediately upon receipt of grant funding.

Previous Awards
Below is information about prior IGT awards to the two highest scoring RFP responders:

- *Coalition of Orange County Community Clinics*: Prior to IGT 6/7, had not previously received a grant. The Board awarded $6,000,000 for Medication Assisted Treatment under IGT 6/7 to the Coalition on August 1, 2019; contracting is in progress and the funds have not yet been released.

- *Healthy Smiles for Kids of Orange County*: Previously received a grant under IGT 2 for $400,000 in June 2015 to use two mobile units (one then recently acquired) to expand school-based dental service from 36 to 50 schools including dental screenings, education and preventive care. Activities included developing proposals and enlisting support of school principals and nurses to attain school district approval, developing proposals for school boards, identifying target schools, educating school principals, nurses, teachers and parents, professional and administrative staff, and supplies for a recently acquired mobile unit. The final report on this grant reflecting the objectives, activities, evaluation indicators and timeline was submitted on June 20, 2017 reflecting that by the end of the first year, 56 new sites had been added (some lower volume schools were removed from the program). Total screenings and sealants per year prior to the grant term were 8-10,000 and 3,000 respectively; during the two-year grant term, nearly 30,000 students were screened and more than 31,000 sealants applied.

Fiscal Impact
The recommended action to award up to $1 million in grant funding from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT 5 funds are accounted for separately. Expenditure of IGT 5 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 of working Better. Together, CalOptima, as the Medi-Cal health plan for Orange County, continues to work with our provider and community partners to address the health needs of Orange County Medi-Cal beneficiaries, filling in gaps and working to improve the availability, access and quality of health care services CalOptima members receive.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Covered Entities
2. PowerPoint Presentation: IGT 5 Community Grant Award Consideration: Children's Dental.
3. Scope of Work IGT 5 RFP 1 Children's Dental
4. Evaluation Matrix
5. CalOptima Board Action dated June 7, 2018, Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)
6. CalOptima Board Action dated December 6, 2018, 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
7. CalOptima Board Action dated August 1, 2019, Consider Allocation of Intergovernmental Transfer (IGT) 5 Funds Towards Community Grants
8. Healthy Smiles for Kids of Orange County Final Report dated June 30, 2017 with referenced spreadsheet
9. IGT 5 Community Grant Application Summary Ad Hoc Top 2 Proposals

/s/ Michael Schrader *9/25/2019*
Authorized Signature **Date**

Attachment 1 to October 3, 2019 Board of Directors Meeting – Agenda Item 12

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
Coalition of Orange County Community Health Centers	515 N. Cabrillo Park Dr. Ste. 225	Santa Ana	CA	92701
Healthy Smiles for Kids of Orange County	10602 Chapman Ave., Ste. 200	Garden Grove	CA	92840
	2010 E. Fourth Street, Ste. A220	Santa Ana	CA	92705
Kha Dang Le Dental Corporation	2121 East Coast Hwy, # 220	Corona Del Mar	CA	92625
	146 S Main St Ste M	Orange	CA	92868
	9900 McFadden Ave, Ste 101	Westminster	CA	92683
Vista Community Clinic	1000 Vale Terrace Drive	Vista	CA	92084
	201 S Harbor Blvd	La Habra	CA	90631

Back to Agenda Back to Item

Back to Agenda

Back to Item

IGT 5 Community Grant Award Consideration: Children's Dental Services

Board of Directors Meeting

October 3, 2019

Candice Gomez

Executive Director, Program Implementation

Back to Agenda

Back to Item

IGT 5 Background

Back to Agenda

- April 2016: Board approved five priority areas
- December 2016: Authorized Member Health Needs Assessment
  - February 2018: Assessment completed
- June 2018: Released Requests for Information (RFI)
  - July 2018: Received 93 RFI responses
- December 2018: Board approved $11.4 million for Be Well Wellness Hub and the release of three RFPs
  - Access to Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Access to Adult Dental Services
- February 2019: Received 20 RFP responses
- August 2019: Awarded grants for Primary Care Services and Programs Addressing Social Determinants of Health, and Access to Adult Dental Services, and deferred the grant for Access to Children's Dental Services

Back to Item

Children's Dental Services: Scope of Work

Back to Agenda

- 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 services in addition to exams and screenings as needed
- Include integration with medical care for early childhood through referral for well-check visits

Back to Item

RFP Evaluation Process: Scoring

Back to Agenda

- Review RFP proposals based on set criteria
  - Organization Information (10%)
  - Project Information (55%)
    - Statement of Need (5%)
    - Project Description (20%)
    - Evidence Supporting Approach (5%)
    - Outreach and Education (10%)
    - Sustainability Plan (5%)
    - Population Served (10%)
  - Project Staffing (10%)
  - Project Budget (10%)
  - Work Plan Information (15%)

Back to Item

RFP Evaluation Process: Site Visit

Back to Agenda

- Purpose of a site visit is to augment the quantitative evaluation of written proposals with qualitative information
  - Better understand the organization and its current programs
  - Learn more about the proposed project and how it fits with the organization's mission
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
- Site visits conducted with top two applicants
- Observations from site visits included in staff report

Back to Item

Proposal Descriptions

Back to Agenda

- Coalition of Orange County Community Health Centers (COCCC)
  - Establish a new mobile unit to serve five community health centers
    - Families Together of Orange County, Korean Community Services, North Orange County Regional Health Foundation, Serve the People and Southland Integrated Services
  - Support a new provider of dental services
    - Four of the five centers currently have dental clinics, and this proposal will support the fifth so all can provide preventive and restorative services

Back to Item

- Healthy Smiles for Kids of Orange County (Healthy Smiles)
  - Enhance four mobile units and a mini clinic to ramp up restorative care (e.g., staff, equipment, supplies, outreach and engagement)
  - Increase access to preventive and restorative care

Top Applicants' Evaluation Scores

Back to Agenda

	Evaluation Criteria										
	Organization	Statement	Description	Evidence	Outreach	Sustainability	Population	Staffing	Budget	Workplan	Grand Total
Coalition of Orange County Community Health Centers											
Score	15	15	15	14	15	14	14	13	15	15	145
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.5	0.75	3	0.7	1.5	0.7	1.4	1.3	1.5	2.25	4.87
Healthy Smiles for Kids of Orange County											
Score	14	15	14	13	13	11	15	15	14	14	138
Weight	10%	5%	20%	5%	10%	5%	10%	10%	10%	15%	100%
Total Score	1.4	0.75	2.8	0.65	1.3	0.55	1.5	1.5	1.4	2.1	4.65

Back to Item

Key Considerations

Back to Agenda

- Ramp-up time for service delivery
  - COCCC: One year of capacity building
  - Healthy Smiles: Immediate expansion of current program
- Number of children served during grant term
  - COCCC: 9,000 children via 6 school districts and other partners
  - Healthy Smiles: 13,500 children via 11 school districts and other partners
- Sustainability plan
  - COCCC: Services are sustainable through reimbursement since all participating health centers are FQHCs or FQHC Look-Alikes
  - Healthy Smiles: Advocate for support from government agencies and local grant programs; and advocate for reimbursement/ increased coverage for vulnerable populations through Denti-Cal

Back to Item

August Board Meeting Follow-Up

Back to Agenda

- Board directed staff to follow up with finalists regarding a potential adjustment of the grant amounts
  - COCCC: Organization shared new information since the August Board meeting. Coalition received funding commitment from another source for two mobile dental units, reducing in funding needs and ramp up time to five months. With $500,000 in IGT 5 funding, Coalition would serve all 9,000 children and meet all deliverables
  - Healthy Smiles: Organization responded that the proposal is scalable. A reduced award would result in a proportionate reduction in children served (e.g., 50% award, half of 13,500 children served) while otherwise meeting all deliverables

Back to Item

Recommended Board Actions

Back to Agenda

1. Award IGT 5 funds in the amount of up to $1 million for a community grant(s) for Access to Children's Dental Services; and
2. Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contract(s) with the selected community grantee(s)

Back to Item

CalOptima's Mission

Back to Agenda

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

Back to Item

SCOPE OF WORK

IGT 5 Children's Health: Expand Access to Children's Dental Services and Provide Outreach

I. OBJECTIVE

In 2017, CalOptima conducted one of the most extensive and inclusive Member Health Needs Assessment (MHNA) in its 20-plus year history. The results provided critical data to ensure CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. Having the data means CalOptima and the community can make more informed decisions about where to focus improvements.

The MHNA highlighted some key findings that included social determinants of health, mental health, primary care access, provider access and dental care. Overall considerations included:

- Members are culturally diverse and want providers who both speak their language and understand their culture;
- Lack of knowledge and fear of stigma are key barriers to utilizing mental health services;
- Most member are connected to primary care but unsure about what oral health services are covered by CalOptima;
- Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

To help decrease the number/percentage of children who have not seen a dentist within the past 12 months as indicated in CalOptima's Member Health Needs Assessment (MHNA), CalOptima's Board of Directors allocated funds for community grants to support local organizations with expanding access to children's dental services and provide outreach.

Grant funds must be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of grant funds, thus funding is best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

CalOptima is awarding $1 million for children's dental services program(s) that 1) includes partnership/collaboration with other organizations to increase the number of CalOptima members served, 2) provides outreach and education as part of their program to promote awareness, and 3) has the ability to be self-sustainable after grant funds have been exhausted.

II. SCOPE OF WORK BASICS

1) PRODUCTS/SERVICES

a) Provide mobile dental outreach at schools with preventative, restorative treatment/services as well as outreach and education for examinations, screenings, resources, etc.
b) Assist children/families with establishing a dental home close to their home for emergency and regular dental care
c) Provide or partner with other community dental providers to ensure patients receive restorative services in addition to exams and screenings as needed.
d) Include integration with medical care for early childhood through referral for well-check visits

2) SUPPLIER'S RESPONSIBILITIES

(a) Provide a workplan with SMART (specific, measurable, achievable, realistic and time-bound) goals, objectives and major activities.
(b) Perform the specific measure objectives/outcomes and submit tracking towards the results.
(c) Create and demonstrate an outreach and education plan for promoting and connecting proposed services to CalOptima members.
(d) Identify, track and report how many additional CalOptima members will be served.
(e) Identify, track and report how staffing will be allocated to the program/project.
(f) Provide services and activities in a culturally competent and relevant manner.

3) CALOPTIMA'S RESPONSIBILITIES

CalOptima will provide the following templates:
(a) Progress, Annual and Final Report templates;
(b) Project Budget form;
(c) Staffing Plan form;
(d) Coordination and scheduling periodic site visit with grantees.

4) DELIVERABLES

Submit and participate in the following to CalOptima:

(a) **Quarterly Progress Reports**, submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of each project quarter.
(b) **Annual Progress Report**, submitted via CalOptima's grant management system, will be due within thirty (30) calendar days after the end of the first year of this Grant Contract.
(c) **Final Report**, submitted via CalOptima's grant management system, will be due within. thirty (30) calendar days after the end of this Grant Contract. The template for this report is also provided through CalOptima's grant management system.

(d) Payment(s) are contingent upon the receipt and acceptance of timely reports and positive progress in identified goals and objectives**.**
(e) Participate in a pre-scheduled site visit(s) with grantee at location of project services.

5) PERFORMANCE MEASURES

(a) CalOptima actively monitors and evaluates grant progress and requires submission of progress reports with demonstrated positive progress in achieving the identified goals and objectives.
(b) CalOptima may perform additional site visits to evaluate performance.

Back to Agenda

Back to Item

2019 RFP SCORING MATRIX

Section	Criteria	Excellent		Good		Poor
		5	4	3	2	1
A. Organization Information (10%)	Organizational Capacity/Financial Condition/Completeness of Application: -Board/Advisory Members Roster -IRS Determination Letter (if applicable) -Form 990 (if applicable) -Most Recent Audited Financial Statements -Completed IRS W-9 Form -Project Staffing Plan -Project Budget Plan	Organization is in excellent financial standing with high liquidity and minimal risk of insolvency (e.g., revenue is higher than expenses, no debt, healthy cash savings, etc.); demonstrates an excellent track record of service to the community and has the capacity to effectively provide proposed services; all requested items included with application. Board/Advisory Members roster is complete and highly organized/robust.		Organization is in good financial standing with minimal liquidity and moderate risk of insolvency (e.g., revenue is slightly higher than expenses, low debt, satisfactory cash savings, etc.); demonstrates a good track record of service to the community and has the capacity to adequately provide proposed services; some or all requested items included with application. Board/Advisory Members roster is satisfactory.		Organization is in poor financial standing with little to no liquidity and high risk of insolvency (e.g., expenses are higher than revenue, high debt, insufficient cash savings, etc.); demonstrates a poor track record of service to the community and lacks the capacity to effectively provide proposed services; some or none of the requested items included with application. Board/Advisory Members roster is incomplete and not organized/robust.
B. Project Information (55%)	Statement of Need (5%)	Provides a clear and realistic explanation of the issue and need(s) in the community; need(s) identified is supported by local statistics and data.		Provides a basic explanation of the issue and need(s) in the community; need(s) identified is supported by non-local statistics and data.		Provides a poor explanation of the issue and need(s) in the community; need(s) identified are not supported by any statistics or data.
	Project Description (20%)	Provides clear and insightful project information; detailed and sensible plan on how goals and outcomes will be achieved. Proposed project has significant potential to address the identified unmet need in the community. Seeks very appropriate collaborations to increase the effectiveness of proposed project.		Provides basic project information; adequate plan on how goals and outcomes will be achieved. Proposed project has minor potential to address the identified unmet need in the community. Seeks basic collaborations to increase the effectiveness of proposed project.		Provides unclear and poor project information; poor plan on how goals and outcomes will be achieved. Proposed project has little to no potential to address the identified unmet need in the community. Seeks little to no collaborations to increase the effectiveness of proposed project.
	Evidence Supporting Approach (5%)	Provides clear and relevant evidence regarding promising practices to support the efficacy of the proposed project.		Provides some generalized evidence regarding promising practices to support the efficacy of the proposed project.		Provides unclear and irrelevant evidence regarding promising practices to support the efficacy of the proposed project.

Back to Agenda

Back to Item

Back to Agenda

Back to Item

2019 RFP SCORING MATRIX

Section	Criteria	Excellent		Good		Poor
		5	4	3	2	1
B. Project Information (55%)	Outreach and Education Strategy (10%)	Provides clear and specific information on how applicant will promote and connect CalOptima members to proposed services; clear and detailed description on how applicant will specifically track the number of CalOptima members reached.		Provides basic information on how applicant will promote and connect CalOptima members to proposed services; adequate description on how applicant will specifically track the number of CalOptima members reached.		Provides insufficient and unclear information on how applicant will promote and connect CalOptima members to proposed services; poor and unclear description on how applicant will specifically track the number of CalOptima members reached.
	Sustainability Plan (5%)	Provides clear and specific information on how the project will be sustained after grant support has ended; plan is very compelling and feasible.		Provides basic information on how the project will be sustained after grant support has ended; plan is adequate and slightly feasible.		Provides poor information on how the project will be sustained after grant support has ended; plan is not compelling and feasible.
	Population Served (10%)	The number of additional CalOptima members served is relatively high and is greater than or equal to 25% of CalOptima members currently served; demonstrates a strong awareness of the demographics and diverse needs throughout Orange County.		The number of additional CalOptima members served is less than 25% of CalOptima members currently served; demonstrates an adequate awareness of the demographics and diverse needs throughout Orange County.		The number of additional CalOptima members served is relatively low and is less than 10% of CalOptima members currently served; demonstrates a poor awareness of the demographics and diverse needs throughout Orange County.
C. Project Staffing Plan (10%)	Project Staffing Plan	Provides a complete staffing plan that is appropriate and reasonable for the proposed project. Provides a clear and detailed explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.		Provides a basic staffing plan that lacks detail for the proposed project. Provides a basic explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.		Provides a poor staffing plan that is not appropriate and realistic for the proposed project. Provides a poor explanation on how applicant will identify, track, and report how staffing will be allocated to the project/program.
D. Project Budget Plan (10%)	Project Budget Plan	Provides a complete budget plan that is appropriate and realistic for the proposed project and timeframe; indirect costs do not exceed the 10% limit.		Provides a basic budget plan that lacks detail for the proposed project and timeframe; indirect costs do not exceed the 10% limit.		Provides a budget plan that is not appropriate and realistic for the proposed project and timeframe; indirect costs exceed the 10% limit.
E. Workplan Information (15%)	Workplan Information	Provides a detailed workplan for implementation that is appropriate to the goals and length of the project; activities for objectives are clear and realistic; demonstrates a high likelihood of achieving objectives.		Provides a basic workplan for implementation that is moderately appropriate to the goals and length of the project; activities for objectives are satisfactory; demonstrates an adequate likelihood of achieving objectives.		Provides a poor workplan that is not appropriate to the goals and length of the project; activities for objectives are weak; demonstrates a low likelihood of achieving objectives.

Back to Agenda

Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of 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 IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

Back to Agenda Back to Item

Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

Back to Agenda Back to Item

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal 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. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

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

1/25/2018 — **Date**

Select Pages Redacted

The following Attachments 1-3 to the February 1, 2018 Board Action Request Item 11: *Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization for the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release of Requests for Proposals for Community Grants* are being redacted.

1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary – Member Health Needs Assessment
3. CalOptima Member Survey Data Book

These Attachments are already included above with this September 3, 2020 Board Action Request

Back to Agenda Back to Item

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:

Back to Agenda Back to Item

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**

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**

Back to Agenda Back to Item

Back to Agenda

Back to Item

Community Grant RFP Recommendations

Board of Directors Meeting

December 6, 2018

Cheryl Meronk

Director, Strategic Development

Back to Agenda

Back to Item

IGT 5 Process Summary to Date

Back to Agenda

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

Back to Item

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

IGT 5 Expenditure Process

Back to Agenda

- 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

Back to Item

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

Grant Funding

Back to Agenda

- **$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**

Back to Item

Three Recommended Grant RFPs

Back to Agenda

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**

Back to Item

* Multiple awardees may be selected per RFP

RFP 1

Back to Agenda

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

Back to Item

RFP 2

Back to Agenda

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

Back to Item

RFP 3

Back to Agenda

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

Back to Item

Next Steps*

Back to Agenda

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

Back to Item

* Dates are subject to change based on Board approval

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Allocation of Intergovernmental Transfer 5 Funds

Contact
Candice Gomez, Executive Director, Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocations of IGT 5 funds in the total amount of $3.4 million for community grants; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute grant contracts with the recommended community grantees.

Background
Intergovernmental Transfers (IGTs) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT 1-7 funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus IGT 1-7 funds are best suited for one-time investments or, as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries. Beginning with IGT 8, the IGT funds are viewed by the state as part of the capitation payments CalOptima receives; these payments are to be tied to covered Medi-Cal services provided to Medi-Cal beneficiaries.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net.

On December 1, 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) the results of which would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per the approved priority areas. The MHNA data collection activities were completed in November 2017.

On February 1, 2018, a summary of MHNA results was shared with the CalOptima Board of Directors. Based on the results of the MHNA, the Board additionally approved the release of eight RFPs for $14.4 million community grants in the following categories:

- Adult Mental Health
- Older Adult Mental Health

Back to Agenda
Back to Agenda
Back to Item

- 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

In preparation for the release of the RFPs, staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. On June 7, 2018, the CalOptima Board approved release of Requests for Information related to these eight categories; ninety-three responses in July 2018.

On December 6, 2018, the CalOptima Board of Directors approved $11.4 million of IGT 5 funds to the Be Well Wellness Hub in December 2018. At that time, the Board of Directors also approved the release of the three following RFPs in the total amount of $3.4 million ($3 million remaining in IGT 5 and $400,000 reallocated from IGT 2) for community grants.

Request for Proposal	Priority Area	Allocation Amount
1. Access to Children's Dental Services	Strengthening the Safety Net	$1.0 million
2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Strengthening the Safety Net	$1.4 million
3. Adult Dental Services	Strengthening the Safety Net	$1.0 million

The three RFPs garnered 20 responses. External subject matter experts and 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 IGT 5 Ad Hoc committee comprised of Dr. Nikan Khatibi and Dr. Alexander Nguyen met on July 23, 2019 to discuss the results of the 20 RFP responses for Children's Dental Services, Primary Care Services and Programs Addressing Social Determinants of Health, and Adult Dental Services. Following

the review of the evaluation committee results, the Ad Hoc committee is recommending the following allocation of $3.4 million for IGT 5 board-approved priority areas through three (3) RFPs.

Community Grants

Category	Organization	Funding Amount
RFP 1. Access to Children's Dental Services	Healthy Smiles for Kids of Orange County	$1,000,000
RFP 2. Primary Care Services and Programs Addressing Social Determinants of Health (School-Based Collaborative with Clinics)	Santa Ana Unified School District	$1,400,000
RFP 3 Adult Dental Services	KCS Health Center (Korean Community Services)	$1,000,000

Fiscal Impact

The recommended action to approve the allocation of $3.4 million from IGT 5 funds has no fiscal impact to CalOptima's operating budget because IGT funds are accounted for separately. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT 5 Expenditure Plan Allocation
2. CalOptima Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants
3. CalOptima Board Action dated June 7, 2018, Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)
4. CalOptima Board Action dated December 6, 2018, Consider Authorizing a Contract for Be Well Wellness Hub Services Provided to CalOptima Medi-Cal Members using Intergovernmental Transfer (IGT) 5 Funds
5. CalOptima Board Action dated December 6, 2018, Consider Authorizing Release of Requests for Proposal (RFPs) for Community Grants to Address Categories from the Intergovernmental

Back to Agenda
Back to Agenda
Back to Item

Transfer (IGT) 5 Funded CalOptima Member Health Needs Assessment and Authorizing Reallocation of IGT 2 Funds.

6. List of responders by RFP category.

/s/ Michael Schrader *7/24/19*
Authorized Signature **Date**

Back to Agenda

Back to Agenda

Back to Item

IGT 5 Community Grant Award Consideration

Board of Directors Meeting

August 1 2019

Candice Gomez

Executive Director, Program Implementation

Back to Agenda

Background

Back to Agenda

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population

Back to Item

- CalOptima Board of Directors approved IGT 5 priority areas for community-based funding opportunities
  - Childhood Obesity
  - Mental Health (Adult and Children's)
  - Improving Children's Health
  - Strengthening the Safety Net

IGT 5 Background Summary

Back to Agenda

Board authorized Member Health Needs Assessment (MHNA) to guide expenditure of IGT5 funds

MHNA identified categories for community grants

Board authorized 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 authorized the release of 3 RFPs

Back to Item

Back to Agenda

RFP Evaluation Criteria

Back to Agenda

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Back to Item

Site Visits

Back to Agenda

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

Back to Item

RFP Summary

Back to Agenda

RFP	Total Received	Total Recommended
1. Access to Children's Dental Service ($1.0 million)	5	1
2. Primary Care Services & Social Determinants of Health ($1.4 million)	6	1
3. Access to Adult Dental Service ($1.0 million)	9	1
Total	**20**	**3**

Back to Item

1. Access to Children's Dental Service ($1 million)

Back to Agenda

Organization	Original Request	Recommended Funding Amount
Healthy Smiles for Kids of Orange County	$1,000,000	$1,000,000
Total	**$1,000,000**	**$1,000,000**

Back to Item

2. Primary Care Services & Social Determinants of Health ($1.4 million)

Back to Agenda

Organization	Original Request	Recommended Funding Amount
Santa Ana Unified School District	$1,400,000	$1,400,000
Total Awarded	**$1,400,000**	**$1,400,000**

Back to Item

3. Access to Adult Dental Service ($1.0 million)

Back to Agenda

Organization	Original Request	Recommended Funding Amount
KCS Health Center (Korean Community Services)	$987,600	$1,000,000
Total	**$987,600**	**$1,000,000**

Back to Item

Recommended Board Actions

Back to Agenda

- Approve the recommended allocations of IGT 5 funds in the amount of $3.4 million for community grants; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

Back to Item

CalOptima's Mission

Back to Agenda

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

Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

Back to Agenda
Back to Agenda
Back to Item

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

Back to Agenda
Back to Agenda
Back to Item

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal 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.

Back to Agenda
Back to Agenda
Back to Item

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

Back to Agenda

Select Pages Redacted

The following Attachments 1-3 to the February 1, 2018 Board Action Request Item 11: *Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization for the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release of Requests for Proposals for Community Grants* are being redacted.

1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary – Member Health Needs Assessment
3. CalOptima Member Survey Data Book

These Attachments are already included above with this September 3, 2020 Board Action Request

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of 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 IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

Back to Agenda
Back to Agenda
Back to Item

Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

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

5/30/2018 — **Date**

Back to Agenda
Back to Agenda
Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

Back to Agenda
Back to Agenda
Back to Item

#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

Back to Agenda
Back to Agenda
Back to Item

6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal 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.

Back to Agenda
Back to Agenda
Back to Item

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

Back to Agenda

Select Pages Redacted

The following Attachments 1-3 to the February 1, 2018 Board Action Request Item 11: *Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization for the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release of Requests for Proposals for Community Grants* are being redacted.

1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary – Member Health Needs Assessment
3. CalOptima Member Survey Data Book

These Attachments are already included above with this September 3, 2020 Board Action Request

Back to Agenda Back to Item

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:

Back to Agenda
Back to Agenda
Back to Item

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**

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**

Back to Agenda
Back to Agenda
Back to Item

Back to Agenda

Back to Item

Community Grant RFP Recommendations

Board of Directors Meeting

December 6, 2018

Cheryl Meronk

Director, Strategic Development

Back to Agenda

IGT 5 Process Summary to Date

Back to Agenda

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

Back to Item

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

Back to Agenda

IGT 5 Expenditure Process

Back to Agenda

- 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

Back to Item

- Ad Hoc Committee reviewed all 93 RFI responses
  - Recommended grant to Be Well OC for first Wellness Hub
  - 3 RFPs proposed

Grant Funding

Back to Agenda

- **$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**

Back to Item

Three Recommended Grant RFPs

Back to Agenda

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**

Back to Item

* Multiple awardees may be selected per RFP

Back to Agenda

CalOptima A Public Agency Better. Together.

RFP 1

Back to Agenda

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

Back to Item

RFP 2

Back to Agenda

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

Back to Item

RFP 3

Back to Agenda

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

Back to Item

Next Steps*

Back to Agenda

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

Back to Item

* Dates are subject to change based on Board approval

Back to Agenda

RFP 1. Access to Children's Dental Service				
Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 156,064	Expansion of Portable Oral Health Services and Tele-dentistry in Orange County	Expand access to portable Oral Health Unit services through addition of a Dental Hygienist and introduce a tele-dentistry component into the program.	600
Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	Provide a dental home with a mobile dental unit equipped to provide pediatric preventive and restorative treatment, thereby completing the circle of dental care. This project will enable five federally qualified health centers (FQHC) and FQHC Look-Alikes to establish a dental home with regular and emergency care for children and families	9,000
Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	Provide preventive (screenings, dental cleanings, fluoride, sealants) and restorative treatment (fillings and cavity treatment) to CalOptima children at schools, primary care clinics, and community sites. Children who require advanced restorative treatment (such as treatment under general anesthesia) will be referred to traditional clinics in Garden Grove and CHOC Children's Hospital.	13,564
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Children	Educate members on optimal dental health by creating a strong traditional and social media presence. Provide exams and screenings to students in a mobile dental vehicle.	1,000

Back to Agenda

Back to Agenda

Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Children in North Orange County	Develop a mobile dental care program in conjunction with the school districts and schools to do full dental exams, take x-rays, place sealants, and address problems such as dental caries.	1,310

RFP 2. Primary Care Services & Social Determinats of Health

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
CHOC Children's	$ 1,396,813	The School-based Student Wellness Center: Addressing the Social Determinants of Health Where Children Are	Create three School-based Student Wellness Centers within three Orange County school districts and enhance current mental health OC Department of Education (OCDE) offerings with novel physical health and social determinant services led by a school site Coordinator and staffed by medical, nutrition, fitness, and social services personnel.	3,886
Coalition of Orange County Community Health Centers	$ 1,400,000	Healthy Kids, Healthy Schools	Collaborate with five schools in establishing school-based wellness centers throughout Orange County. These wellness centers will provide immunizations, health screenings, health education, and direct comprehensive health care (medical, dental, vision, and behavioral health) with community clinics. Six letters of support from schools/school districts were submitted.	5,500

Back to Agenda

Back to Agenda

Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
NAMI Orange County	$ 174,794	Decreasing Stigma Through Mental Health Education, While Increasing Access to Wellness Resources	NAMI-OC will host Ending the Silence (ETS) presentations and conduct outreach at schools to further educate and increase awareness surrounding mental health conditions. Resource Navigation services will also be offered for students and their families.	13,590
Santa Ana Unified School District	$ 1,400,000	Family and Community Engagement (FACE) Wellness Centers	Enhance the Family and Community Engagement (FACE) Wellness Centers at all 57 K-12 school sites across the school district. Service providers, healthcare professionals, and local clinics will conduct services within the centers which are located within walking distance from the homes of families and residents of the entire Santa Ana community. SAUSD collaborates with local stakeholders; business organizations, institutions of higher learning, for-profit and nonprofit organizations in order to provide wrap-around services for students, families and the surrounding community. Several agreements have already been established with service providers to partner with the SAUSD.	50,000

Back to Agenda

Back to Agenda

Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Serving Kids Hope	$ 1,351,412	School-Based Wellness Program	The project formalizes district-wide wellness assessment based on State Wellness Standards, establishing baseline and measurement of impact. It will be data-driven, with district-wide wellness assessment, documented services, and analysis and reporting of outcomes. Two letters of support from school districts were submitted.	25,975
Wellness & Prevention Center	$ 224,631	Expansion and Integration of South Orange County School-Based Wellness Centers into the CalOptima Primary Care Network	Expand five school-based wellness centers and leverage existing agreement with the Capistrano United School District. Project will increase bilingual staff, expand parental engagement, and create educational materials.	300

RFP 3. Access to Adult Dental Service

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
AltaMed Health Services Corporation	$ 150,678	Expanded Access to Adult Dental Services in Orange County	Expand access through the addition of a dental team in the Santa Ana clinic location and expand service hours (evening and weekend). The project also: increases awareness about coverage; promotes timely treatment plan completion; links members to a dental home; and integrates culturally-responsive, language-appropriate dental and medical services.	300

Back to Agenda

Back to Agenda

Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Camino Health Center	$ 50,000	Adult Dental Services Expansion	Camino Health Center will be using funds to provide additional evening and weekend hours in the current dental clinic. The additional hours will allow more patients in the community access to receive dental services with hours that may be more compatible to their personal schedules. The additional funding for elective dental procedures with lab fees will allow patients to have access to procedures not covered by insurances.	150
Families Together of Orange County	$ 1,000,000	Bridging the Gap: Addressing Orange County's Oral Health Needs	Open a new health center with four dental exam rooms located on the border of Garden Grove and Anaheim, targeting patients who speak Arabic, Spanish, or Vietnamese. Dental care will be integrated into FTOC's comprehensive primary care services with evening and weekend hours.	6,000
KCS Health Center (Korean Community Services)	$ 987,600	Integration of MECCA Community Based Organizations with FQHC Adult Oral Care Access in Mobile and Nontraditional Delivery Modalities	KCS Health Center requests to build mobile sites at each of its six (6) partnering MECCA community-based organizations and extend hours of operation to nontraditional hours at the mobile sites as well as at KCS Health Center and Southland Integrated Services locations. The organizations together serve populations that speak Spanish, Vietnamese, Korean, Farsi, Arabic, and Khmer	8,000

Back to Agenda

Back to Agenda

Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Kha Dang Le Dental Corporation	$ 1,000,000	Community Dental Care Access for Adults	Educate members on optimal dental health by creating a strong traditional and social media presence. Add an additional day (on Fridays) for 9 hours to provide more access to care and allow more appointments.	1,000
Livingstone Community Development Corporation	$ 350,000	Finding Your Smile: Expanding Dental Services for Adults Beyond Emergency Care	Expand direct preventive and restorative dental services by increasing dental program staff, extending hours and days of operation and providing improved integration with its primary care program. The dental program will provide exams and x-rays, dental cleaning, cavity fillings, extractions, root canal treatments, and crowns.	2,500
Serve the People	$ 1,000,000	Oral Health for the Homeless	Establish dental care access points with a three-chair dental mobile unit at 10 homeless shelters managed by homeless support service providers. These new dental homes will provide preventative, restorative, and specialized dental care to CalOptima members.	1,500
St. Jeanne de Lestonnac Free Clinic	$ 180,000	Oral Health Program	Increase outreach efforts and purchase equipment and supplies to treat more patients. Dental services include exams, x-rays, fillings, root canals, and tooth extractions. Lab work and/or dental prosthetics will be available to patients at cost with no additional markup.	100

Back to Agenda

Back to Agenda

Back to Item

Organization Name	Request ($)	Project Title	Project Description	Additional CalOptima Members Served
Vista Community Clinic	$ 251,432	Development of a Mobile Dental Care Program for Adults in North Orange County	Develop a mobile dental care program serving adults in La Habra to do full dental exams, x-rays, sealants, and addressing problems such as dental caries. The program will be include an outreach initiative, to helping to raise awareness of safety-net healthcare services, and promoting knowledge of and access to CalOptima's health care services.	1,426

Back to Agenda

Back to Agenda

Back to Item

GRANT REPORT TEMPLATE

GRANTEE INFORMATION

Name of Organization/Tax ID:	Healthy Smiles for Kids of Orange County XX-XXXXXXX
Address:	2101 E. Fourth St., Suite 220A, Santa Ana, CA 92705
Phone Number:	714-537-0700
Contact Name:	Tommie Servi (Ext. 7938) or 714-309-7485
Email:	tservi@healthysmilesoc.org
Is your 501(c)3 status current?	Yes ☒ No ☐ Not Applicable ☐
If no, explain	
Executive Director Name:	Ria Berger
Board Chair Name:	Richard Lee
Chief Financial Officer:	Kim Banco

GRANT INFORMATION

RFP 15-026 Orange County Public School-based Dental Services Grant	
Proposal Title: "Prevention Oral Health for School Aged Children"	

GRANT REPORT INFORMATION

Type of Grant Report

Annual Progress ☐ Final ☒

Report Due Date:	7/1/2017
Report Submission Date:	6/30/2017

Back to Agenda Back to Item

EVALUATION CHART-FOR PROGRESS & FINAL REPORTS

Instructions: Please Submit an Updated Evaluation Chart with "Actuals" tied to Scope of Work in Attachment A

Objectives	Activities	Evaluation Indicators	Timeline
Establish site of dental care at high-need school	Yr 1 was focused on expansion. Healthy Smiles exceeded goals by doubling the number of schools visited; 5 new school districts and 56 new school sites were added; Yr 2 the focus was on improving participation rates in addition to continued expansion efforts. This was achieved by reviewing participation rates of schools in Yr 1 to exclude some of the low volume schools from our current year schedule and creation of a School Relations Coordinator position to work more closely with school staff to increase their engagement, get parent advocates involved and take advantage of communication options within the school system, such as email blasts, school newsletters, announcements at school events, banners in front of the school, etc. The average participation rate in Yr 1 was 23.7%. The participation rate for Yr 2 is 31.7%. Average for two years is 27.7%.	1. MOU's signed for five new school districts. 2. 16 new schools listed in Attachment G 3. 40 new schools not listed on Attachment G 4. 56 total new schools screened 5. Screenings from Expansion into New Schools: 7,468 6. Participation Rate: 27.7%	Jun 2015 – May 2017
Render oral health services and screening to 10,000-12,000 per year students at high-need	We are defining events as each day the mobile unit is at the school – one for each screening day and one for each sealant day depending on number of children to be seen and scheduling. We are collecting data on all schools	1. # of school events: 525 2. # of schools visited: 180 3. Children educated: 98,202	Jun 2015 – May 2017

Back to Agenda Back to Item

schools	screened within the year though some related services may fall outside of the year (education/care coordination).	4. Parents/Teachers Educated: 4,694 5. Screenings: 29,753 6. Fluoride: 27,018 (90.8%) 7. Children Receiving Sealants: 10,470 (35.2%) 8. # of Sealants Applied: 31,698 9. # of children screened with visible decay: 16,125 or 54.2% 10. # of children screened with severe decay: 3.028 or 10.2%	
Connect children to a usual source of dental care	We have seen the number of children needing referral to a dental home decreasing due to increased dental insurance coverage for children and more families are connected to a dental provider. There are also a percentage of cases where we are unable to connect with the parent or they decline assistance.	1. % of children with visible decay who were linked to a dental home: 39% 2. % of children with visible decay who received referral for restorative care: 5.9%	Jun 2015 – May 2017
Track participation rates at schools and service utilization to inform CalOptima	In order to determine whether children identified as needing care have received treatment or completed treatment, care coordinators will need to contact parents subsequent to screening and may require more than one follow up call. Due to this, these numbers will take additional time to accumulate. There are also cases	1. % of parents who did not submit a consent form for their child's participation in the screening event: 72.5%	Jun 2015 – May 2017

Back to Agenda Back to Item

	where care coordinators are unable to connect with the parent or the parent is uncooperative. As a result, we may not be able to identify all patients not receiving or completing treatment. This does not mean they are not getting treatment. Yr 2 %'s are provided but they will not include all outcomes from schools visited in the last quarter or from those parents that we were unable to contact or who refused to speak with us. Since there is a significant time lag in gathering this information, it will not be complete for reporting on quarterly reports. Note that 33.2% of parents declined care coordination. Of those who did not decline HSK care coordination, 29.2% HSK was unable to make a connection and 2.3% refused assistance.	2. % of children who did not ***receive*** treatment after being identified as needing care: In Yr 2 – 19.7% could be confirmed as receiving treatment (note this is based on the number of children whose parents accepted care coordination) 3. % of children who did not ***complete*** treatment after being identified as needing care: In Yr 2 – 14.6% could be confirmed as completing treatment (note this is based on the number of children whose parents accepted care coordination)	

Back to Agenda Back to Item

QUESTIONAIRE	
TRACKING DATA - FOR ALL REPORTS	
1. Total number of events	525
2. Number of participating schools	180
3. For each school where services are rendered, please provide the following information: a) Name and address of the school b) Main contact person at the school who can verify that services were rendered c) Total number of students enrolled at the school and the percentage of students who received dental services d) Age range of children served (e.g. 5-11 years) at each school e) Number and percentage of children served who had visible decay f) Number of referrals for restorative care	See attached spreadsheet

Back to Agenda Back to Item

FOR ANNUAL PROGRESS REPORTS (Due on annual basis)	YOUR ANSWERS
1. Please describe progress towards the performance target/milestones being reported on. If progress was not made, please describe why.	HSK exceeded targets in all areas.
2. Have you made any deviations from your original proposal? Explain how these deviations have, or will impact the project.	No, focus is the same. Addition of new FQHC allowed us to serve more schools.
3. Have you encountered any unexpected successes or challenges during this reporting period?	Have signed new FQHC contracts that will allow us to continue to expand services.
4. Are you requesting any changes to the project workplan or grant outcome? Please explain.	No
FOR FINAL REPORT (Due 30 days after completion of contract)	**YOUR ANSWERS**
1. Were you able to meet the desired outcomes of this grant? Please explain.	Yes, have exceeded goals.
2. What were the key variables contributing to your success or failure?	Strong relationships with FQHC's and school districts.
3. Please describe any unexpected successes or challenges you have experienced as a result of the grant. How have these items impacted the project and/or organization?	The grant allowed us to significantly expand. The first year of the grant, HSK doubled the number of schools served.
4. Please list any organizational or programmatic changes that will be made as a result of the grant experience.	HSK was able to implement processes that allow us to serve more schools each year. Our success will allow us to attract new school districts and FQHC partners.

Back to Agenda Back to Item

5. Do you have any additional information about your project or the grant experience you would like to share with CalOptima?	We appreciate the support from CalOptima. For HSK, it's all about the kids. We were able to serve so many more children as a result of CalOptima support.

Back to Agenda Back to Item

FINANCIALS-FOR ANNUAL PROGRESS AND FINAL REPORTS			
COLUMN 1- PROJECTED EXPENSES	COLUMN 2- ACTUAL EXPENSES	COLUMN 3- DIFFERENCES BETWEEN PROJECTED AND ACTUAL EXPENSES	COLUMN 4- EXPLANATION OF DIFFERENCES
241,438	241,438	-0-	Staffing – hired additional staff due to change in program structure and to provide coverage for increase in services
96,668	96,668	-0-	Supplies – mobile unit expenses are higher due to unanticipated repairs. Dental supplies higher due to servicing more children than anticipated.
47,542	47,542	-0-	Facilities, Telephone, IT – lower allocation of space for Prevention team due to expansion of other programs that are picking up a larger portion
14,352	14,352	-0-	Other expenses – printing costs less than expected due to implementation of scanning processes. Cushion built into this category was not utilized.
400,000	400,000	-0-	Totals

Back to Agenda Back to Item

QUESTIONS	ANSWERS
1. List the organization names and grant amounts of all sub-grantees and/or consultants indirectly receiving Foundation funds from this grant.	NA

***NOTE**-Please note that if there are any remaining funds from the grant, CalOptima will require you to document an appropriate use regarding how you intend to spend the funds.*

Back to Agenda Back to Item

I hereby certify that this report, including any attachments, is accurate to the best of my knowledge, and that our organization, remains in full compliance with the terms of the Grant Contract. (Signatures are required for each position listed below)	
Primary Contact for Project	
Name:	Tommie Servi
Title:	Vice President of Operations
Signature:	Tommie Servi
Date:	June 30, 2017
Executive Director or Board Chair	
Name:	Ria Berger
Title:	Chief Executive Officer
Signature:	Ria Berger
Date:	June 30, 2017
Chief Financial Officer	
Name:	Kim Banco
Title:	Vice President of Finance
Signature:	
Date:	June 30, 2017

Back to Agenda Back to Item

CALOPTIMA TRACKING DATA - Final Years 1 & 2

Healthy Smiles for Kids of Orange County - RFP 15-026

Back to Agenda

1. Total number of events: 525

2. Number of participating schools: 89

NM	Newport Mesa
OV	Oceanview
SA	Santa Ana
SV	Savanna
TU	Tustin
WE	Westminster

*Includes parents and teachers

SCREENING DATE	SCHOOL DISTRICT	EVENTS	SCHOOL	ADDRESS	CITY/STATE	POSTAL CODE	CURRENT(CUR)/TARGET(TAR)/NEW(NEW)	SCHOOL POPULATION	CHILDREN SCREENED	EXPANSION	FLUORIDE	CHILDREN RECEIVING SEALANTS	# OF SEALANTS APPLIED	% WHO RECEIVED SERVICES	AGE RANGE	NUMBER OF CHILDREN WITH VISIBLE DECAY	% OF CHILDREN SERVED WITH VISIBLE DECAY	# OF CHILDREN WITH SEVERE DECAY (EMERGENCY)	ORAL HEALTH EDUCATION PROVIDED *	DECLINED CARE COORDINATION	LINKED TO DENTAL HOME	NUMBER OF REFERRALS FOR RESTORATIVE CARE	NOT CONNECTED	IN TREATMENT	TREATMENT COMPLETED	UNABLE TO CONFIRM TREATMENT	REFUSED TREATMENT
4/28/2016	NM	3	Adams Elementary	2850 Clubhouse Rd.	Costa Mesa, CA	92626	NEW	427	155	155	139	61	196	36.3%	5-12	74	47.7%	11	456	57	2		1				
1/25/2016	GG	2	Anthony Elementary	15320 Pickford St.	Westminister, CA	92683	NEW	467	146	146	134	51	167	42.7%	5-12	68	46.6%	19	490	39	32	3	15	3	14	8	1
11/9/2015	CY	2	Arnold Elementary	9281 Denni St.	Cypress, CA	90630	TAR	748	91	91	83	31	114	12.2%	5-12	34	37.4%	1	764	35	18	2	6	2	7	3	
2/25/2016	MA	2	Baden-Powell Elementary	2911 W. Stonybrook Dr.	Anaheim, CA	92804	NEW	734	60	60	53	25	61	8.2%	5-12	32	53.3%	8	708	24	11	2	11	1	3	1	2
12/14/2015	TU	3	Benson Elementary	12712 Elizabeth Way	Tustin, CA	92780	TAR	353	41	41	37	7	27	11.6%	5-12	20	48.8%	0	369	13	10	1	3		6		
11/3/2015	TU	4	Beswick Elementary	1362 Mitchell Ave.	Tustin, CA	92780	TAR	683	286	286	239	72	248	41.9%	5-12	139	48.6%	27	660	96	75	14	27	10	30	13	
4/4/2016	GG	3	Brookhurst Elementary	9821 Catherine Ave.	Garden Grove, CA	92841	CUR	514	180		165	69	289	35.0%	5-12	83	46.1%	15	532	66	43	2	15	3	3		2
2/29/2016	GG	2	Bryant Elementary	8371 Orangewood	Garden Grove, CA	92841	CUR	760	166		155	85	218	21.8%	5-12	99	59.6%	18	770	70	60	13	31	9	10	23	
10/5/2015	CE	2	Buena Terra Elementary	8299 Holder St.	Buena Park, CA	90620	CUR	508	70		65	27	100	13.8%	5-12	33	47.1%	5	542	30	16	4	5	1	7	4	1
9/24/2015	CE	3	Centralia Elementary	195 N. Western Ave.	Anaheim, CA	92801	CUR	582	170		157	60	139	29.2%	5-12	116	68.2%	5	561	61	51	7	31	3	21	18	
2/18/2016	SV	2	Cerritos Elementary	3731 Cerritos	Anaheim, CA	92804	NEW	502	67	67	62	31	81	13.3%	5-12	32	47.8%	8	550	18	20	3	5	3	9	5	
12/1/2015	GG	1	Clinton Corner Pre-School	13581 Clinton St.	Garden Grove, CA	92843	CUR	240	135		118	0	0	56.3%	3-5	74	54.8%	9	259	29	36	7	26	3	14		
8/29/2016	GG	2	Clinton Elementary	13641 Clinton St.	Garden Grove, CA	92843	NEW	695	171	171	133	49	187	24.6%	5-12	67	39.2%	9	718	64	20	2	28		2		2
12/13/2015	GG	2	Cook Elementary	9802 Woodbury Ave.	Garden Grove, CA	92844	CUR	389	89		83	38	128	22.9%	5-12	37	41.6%	3	369	32	17	3	9		8	5	1
8/25/2015	CE	3	Danbrook Elementary	320 Danbrook St.	Anaheim, CA	92804	CUR	672	262		235	45	155	39.0%	5-12	138	52.7%	10	662	101	69	14	31	21	33	13	
5/11/2016	SA	1	Davis Elementary	1405 French St	Santa Ana, CA	92701	CUR	747	140		127	42	133	18.7%	5-12	89	63.6%	15	680	42	53	7	16	9	18	6	3
&	SA	2	Diamond Elementary	1450 S. Center St.	Santa Ana, CA	92704	CUR	600	311		277	131	381	51.8%	5-12	179	57.6%	71	598	48	85	23	36	14	30	13	1
4/26/2016	MA	2	Disney Elementary	2323 W. Orange Ave.	Anaheim, CA	92804	NEW	671	147	147	130	51	180	21.9%	5-12	67	45.6%	9	705	72	1		1		1		1
9/15/2015	CE	2	Dysinger Elementary	7770 Camellia Dr.	Buena Park, CA	90620	CUR	534	97		94	32	111	18.2%	5-12	34	35.1%	5	531	38	12	4	10	1	3	5	
&	AN	4	Edison Elementary	1526 E. Romneya	Anaheim, CA	92805	CUR	1002	219		200	81	246	21.9%	5-12	94	42.9%	9	928	90	55	12	19	11	25	8	4
6/2/2015	SA	3	El Sol Elementary	1010 N. Broadway St.	Santa Ana, CA	92701	CUR	800	175		162	57	203	21.9%	5-12	68	38.9%	10	591	79	28	9	11		15	3	
12/15/2016	TU	2	Estock Elementary	14741 North B Street	Tustin, CA	92780	TAR	384	92	92	81	28	97	24.0%	5-12	54	58.7%	9	389	32	27	9	11		5		
6/1/2015	GG	3	Faylane Elementary	11731 Morrie Ln.	Garden Grove, CA	92840	CUR	628	83		79	50	184	13.2%	5-12	47	56.6%	8	488	22		1					
3/22/2016	GG	2	Faylane Elementary	11731 Morrie Ln.	Garden Grove, CA	92840	CUR	610	121		113	44	163	19.8%	5-12	57	47.1%	12	479	34	29	4	14	5	6		
11/17/2015	TU	2	Foss Elementary	18492 Vanderlip Ave.	Santa Ana, CA	92705	NEW	452	43	43	41	17	57	9.5%	5-12	14	32.6%	0	401	21	7	2	1		1	1	
10/19/2015	AN	3	Franklin Elementary (Anaheim)	521 W. Water St.	Anaheim, CA	92805	CUR	879	128		122	49	172	14.6%	5-12	65	50.8%	11	895	49	29	4	16	3	16	8	1
10/20/15	SA	5	Franklin Elementary (Santa Ana)	210 W. Cubbon St.	Santa Ana, CA	92701	CUR	489	193		176	60	245	39.5%	5-12	110	57.0%	11	469	67	48	9	24	9	14	11	2
3/10/2016	GG	2	Gilbert Elementary	9551 Orangewood Ave.	Garden Grove, CA	92841	NEW	530	96	96	89	38	106	18.1%	5-12	60	62.5%	6	539	25	27	3	19	3	2		
2/1/2016	SV	2	Hansen Elementary	1300 South Knott	Anaheim, CA	92804	NEW	690	126	126	117	51	155	18.3%	5-12	60	47.6%	9	719	46	23	5	15	3	3	9	
4/14/2016	SA	3	Harvey Elementary	1635 S. Center St.	Santa Ana, CA	92704	CUR	447	168		147	81	220	37.6%	5-12	79	47.0%	20	479	61	41	9	14	3	1		1
10/12/2015	GG	3	Hazard Elementary	4218 West Hazard Ave.	Santa Ana, Ca	92703	NEW	630	153	153	140	50	217	24.3%	5-12	64	41.8%	8	630	40	36	9	21	3			1
1/19/2016	TU	3	Heideman Elementary	15571 William St	Tustin, CA	92780	TAR	630	214	214	192	89	311	34.0%	5-12	107	50.0%	14	655	64	55	12	22	9	28	7	
10/27/2015	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	600	157		139	57	196	26.2%	5-12	63	40.1%	3	573	71	30	5	7	1	9	6	2
3/1/2016	GG	2	Hill Elementary	9681 11th St.	Garden Grove, CA	92844	NEW	370	88	88	84	39	133	23.8%	5-12	35	39.8%	10	383	22	17	3	11	3			
2/11/2016	SV	2	Holder Elementary	9550 Holder St.	Buena Park, CA	90620	NEW	560	87	87	80	31	109	19.6%	5-12	40	46.0%	6	557	33	16	4	12	1	3	7	2
6/9/2015	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	1126	154		132	48	174	13.7%	5-12	60	39.0%	5	1046	39		1	12	9	9		
11/5/2015	SA	3	Jefferson Elementary	1522 W. Adams St.	Santa Ana, CA	92704	CUR	897	147		137	51	148	16.4%	5-12	79	53.7%	30	814	43	49	13	14	3	14	12	1
11/2/2015	CY	2	King Elementary	8710 Moody St.	Cypress, CA	90630	TAR	585	65	65	62	27	100	11.1%	5-12	19	29.2%	3	584	27	7		4	1	4		1
11/13/2015	TU	3	Lambert Elementary	1151 San Juan St.	Tustin, CA	92780	TAR	523	169	169	156	65	243	32.3%	5-12	71	42.0%	8	435	55	41	10	21	4	13	14	
8/19/2015	CY	3	Landell Elementary	9739 Denni St.	Cypress, CA	90630	TAR	750	63	63	52	20	68	8.4%	5-12	29	46.0%	4	737	33	12	1	3		7	1	4
9/14/2015	CE	2	Los Coyotes Elementary	8122 Moody St.	La Palma, CA	90623	CUR	529	90		79	41	148	17.0%	5-12	34	37.8%	4	575	41	16	2	7	1	6	2	4
2/22/2016	MA	2	Low Elementary	215 N. Ventura St.	Anaheim, CA	92801	NEW	704	101	101	91	48	93	14.3%	5-12	49	48.5%	10	729	28	25		7	3	10	4	
1/21/2016	SA	5	Lowell Elementary	700 S Flower St	Satna Ana, CA	92703	CUR	900	307		292	135	342	34.1%	5-12	164	53.4%	38	947	91	82	20	32	7	33	14	3
10/26/2015	CY	2	Luther Elementary	4631 La Palma Ave.	La Palma, CA	90623	TAR	515	59	59	53	20	71	11.5%	5-12	19	32.2%	0	535	20	9	1	10		1	1	
8/3/2015	AN	3	Mann Elementary (Tracks BC)	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	668	125		118	53	188	18.7%	5-12	64	51.2%	9	609	47	41	16	8	7	14	4	1
12/7/2015	GG	3	Marshall Elementary	15791 Bushard St.	Westminister, CA	92683	TAR	456	109	109	96	48	150	23.9%	5-12	58	53.2%	6	472	33	28	28	20		5		
3/15/2016	MA	2	Marshall Elementary	2627 Crescent Ave.	Anaheim, CA	92801	NEW	657	56	56	49	12	47	8.5%	5-12	35	62.5%	4	707	7	10	3	8	1	19		
10/22/2015	SA	5	Martin Elementary	939 W. Wilshire Ave.	Santa Ana, CA	92707	CUR	750	285		262	119	303	38.0%	5-12	129	45.3%	62	767	86	70	16	31	3	24	12	

Back to Agenda

Back to Item

4/25/2016	MA	3	Maxwell Elementary	2613 W. Orange Ave.	Anaheim, CA	92804	NEW	802	206	206	177	70	182	25.7%	5-12	108	52.4%	12	871	63	14	2			1		
9/8/2015	CE	2	Miller Elementary	7751 Furman Rd.	La Palma, CA	90623	CUR	579	62		52	29	113	10.7%	5-12	25	40.3%	4	612	29	10	3	5	2	5	3	1
3/24/2016	GG	3	Mitchell Elementary	13451 Taft Ave.	Garden Grove, CA	92843	CUR	469	153		137	70	189	32.6%	5-12	80	52.3%	21	463	63	22	2	29		1		
10/16/2015	CY	2	Morris Elementary	9952 Graham St.	Cypress, CA	90630	TAR	737	62	62	52	18	67	8.4%	5-12	26	41.9%	4	763	24	8		8		2	2	
11/19/2015	TU	2	Nelson Elementary	14392 Browning Ave.	Tustin, CA	92780	TAR	620	60	60	52	12	29	9.7%	5-12	38	63.3%	13	649	21	17	7	8	2	6	3	
6/10/2016	GG	1	Newhope Elementary	4419 West Regent Dr.	Santa Ana, CA	92704	NEW	431	63	63	63	2	3	14.6%	5-12	33	52.4%	4	416	24	16	7	5		1		1
4/3/2016	OV	3	Oakview Elementary	17241 Oak Lane	Huntington Beach, CA	92647	CUR	709	201		182	82	193	28.3%	5-12	96	47.8%	20	689	77	41	2	16	1	1		1
10/10/2015		1	Oakview Pre-School	17241 Oak Lane	Huntington Bch, CA	92647	CUR	320	81		75	0	0	25.3%	3-5	38	46.9%	2	281	23	19	3	9	2	9	9	1
11/12/2016	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	500	81		80	45	161	16.5%	5-12	35	43.2%	5	574	25	19	7	10		11		
4/12/2016	NM	2	Paularino Elementary	1060 Paularino Ave.	Costa Mesa, CA	92626	NEW	485	130	130	117	48	166	26.8%	5-12	47	36.2%	10	445	46	24	5	10	2			1
4/5/2016	GG	2	Peters Elementary K-2	13162 Newhope St.	Garden Grove, CA	92843	CUR	1180	172		164	67	211	9.7%	5-12	109	70.2%	150	1262	53	59	14	20	6	18	9	2
11/12/2015	SA	3	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	634	155		145	20	134	24.4%	5-12	85	54.8%	29	635	46	38	9	25	6	14	7	1
&8/24/2015	AN	3	Ponderosa Elementary	2135 S. Mountain View Avenue	Anaheim, CA	92802	CUR	1032	324		291	123	441	31.4%	5-12	159	49.1%	35	1041	99	84	17	60	16	40	20	4
3/17/2016	MA	3	Pyles Elementary	10411 S. Dale Ave.	Stanton, CA	90680	NEW	721	142	142	117	61	157	19.7%	5-12	71	50.0%	19	791	56	66	8	19	2	3		2
5/16/2016	NM	4	Rea Elementary	661 Hamilton St.	Costa Mesa, CA	92627	NEW	502	192	192	177	64	195	38.2%	5-12	118	61.5%	23	502	43	4						
2/2/2016	SV	3	Reid Elementary	720 S. Western Ave.	Anaheim, CA	92804	NEW	657	147	147	138	67	263	22.4%	5-12	66	44.9%	17	706	49	35	3	13	1	11	11	2
6/8/2015	SA	4	Remington Elementary	1325 E. Fourth St.	Santa Ana, CA	92701	TAR	339	87	87	83	72	247	25.7%	5-12	36	41.4%	5	331	30	32	3					
11/30/2015	SA	2	Remington Elementary	1325 E. Fourth St.	Santa Ana, CA	92701	CUR	319	69	69	64	22	76	21.6%	5-12	43	62.3%	9	363	9	28	2	13	6	10	12	
5/3/2016	AN	5	Revere Elementary	140 W. Guinida Lane	Anaheim, CA	92805	CUR	921	314		285	130	480	34.1%	5-12	181	57.6%	21	955	118	5	1					
5/10/2016	GG	3	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	553	164		158	65	227	29.7%	5-12	72	43.9%	13	585	57	2						
2/23/2016	GG	3	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	569	184		173	76	204	32.3%	5-12	89	48.4%	15	535	67	48	4	15	6	13	16	2
4/21/2016	AN	3	Ross Elementary	535 S. Walnut St.	Anaheim, CA	92802	CUR	1005	176		163	88	201	17.5%	5-12	83	47.2%	12	1008	58	28	3	3	1	5		2
9/28/2015	GG	3	Russell Elementary	600 S. Jackson	Santa Ana, CA	92704	NEW	719	291	291	260	91	336	40.5%	5-12	123	42.3%	24	704	94	62	7	29	9	27	19	4
4/19/2016	MA	2	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	NEW	849	85	85	80	31	116	10.0%	5-12	43	50.6%	5	865	28	19	2	9	2			
9/29/2015	CE	3	San Marino Elementary	6215 San Rolando Way	Buena Park, CA	90620	CUR	583	121		114	41	139	20.8%	5-12	48	39.7%	8	635	48	25	3	18	2	10	8	1
3/8/2016	MA	2	Schweitzer Elementary	229 S. Dale Ave.	Anaheim, CA	92804	NEW	635	64	64	60	21	48	10.1%	5-12	38	59.4%	9	677	21	22	6	5	1	1		2
10/8/2015	SA	3	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	NEW	482	120	120	97	40	105	24.9%	5-12	86	71.7%	27	487	34	45	7	20	3	18	16	1
5/2/2016	NM	4	Sonora Elementary	966 Sonora Rd.	Costa Mesa, CA	92626	NEW	527	164	164	142	59	185	31.1%	5-12	79	48.2%	9	527	48	3	2	1				
9/1 & 9/8/15	AN	5	Sunkist Elementary	500 N. Sunkist St.	Anaheim, CA	92806	CUR	875	288		277	123	380	32.9%	5-12	138	47.9%	15	945	97	69	9	32	8	28	13	
5/12/2016	GG	4	Sunnyside Elementary	9972 East Russell Ave.	Garden Grove, CA	92844	NEW	698	266	266	204	85	257	38.1%	5-12	152	57.1%	26	699	130	1				1		
9/21/2015	CE	2	Temple Elementary	7800 Holder St.	Buena Park, CA	90620	CUR	504	113		106	32	107	22.4%	5-12	39	34.5%	4	532	42	13	6	13		4	2	
4/28/2016	TU	1	Thorman Elementary	1402 Sycamore Ave	Tustin, CA	92780	TAR	572	162	162	145	72	189	28.3%	5-12	89	54.9%	23	591	41	56	6	18	8	23	8	2
2/16/2016	TU	2	Tustin Ranch Elementary	12950 Robinson Dr.	Tustin, CA	92782	NEW	655	83	83	68	30	111	12.7%	5-12	33	39.8%	2	668	34	17	1	9	2	9	4	1
&12/9/15	TU	1	Veeh Elementary	300 South C St.	Tustin, CA	92780	TAR	429	134	134	115	48	166	31.2%	5-12	65	48.5%	12	403	37	32	9	19	5	12	5	3
11/9/2015	CY	2	Vessels Elementary	5900 Cathy Ave.	Cypress, CA	90630	TAR	685	43	43	37	0	0	6.3%	5-12	18	41.9%	0	708	22	7	2		2	1	3	
3/9/2016	NM	2	Victoria Elementary	1025 Victoria St.	Costa Mesa, CA	92627	NEW	363	82	82	73	25	97	22.6%	5-12	47	57.3%	6	388	30	3						
3/31/2016	GG	3	Violette Elementary	12091 Lampson Ave.	Garden Grove, CA	92840	CUR	562	274		254	111	308	48.8%	5-12	91	33.2%	25	542	101	76	10	35	6	5		2
1/14/2016	GG	2	Wakeham Elementary	7772 Chapman Ave	Garden Grove, CA	92840	CUR	354	87		81	39	102	24.6%	5-12	45	51.7%	8	368	33	24	6	6	4	9	1	
4/18/2016	MA	2	Walter Elementary	10802 Rustic Ln.	Anaheim, CA	92804	NEW	607	172	172	138	54	202	28.3%	5-12	64	37.2%	14	669	52	35	9	13	3			
5/5/2016	GG	4	Warren Elementary	12871 Estock Dr.	Garden Grove, CA	92840	NEW	469	246	246	232	112	366	52.5%	5-12	140	56.9%	17	531	95	5						
1/7/2016	WE	2	Webber Elementary	14142 Hoover St	Westminister, CA	92683	CUR	362	114		105	53	142	31.5%	5-12	62	54.4%	17	371	45	25	3	14	5	11	4	1
2/4/2016	OV	3	Westmont/Lake View Elementa	8251 Heil Ave.	Westminister, CA	92801	CUR	912	149		131	59	148	16.3%	5-12	76	51.0%	14	628	59	39	1	19	5	14	11	1
& 4/11/16	NM	5	Whittier Elementary	1800 Whittier Ave.	Costa Mesa, CA	92627	NEW	715	345	345	280	127	371	48.3%	5-12	177	51.3%	27	744	88	99	9	44	7	7		4
5/31/2016	NM	3	Wilson Elementary	801 W. Wilson St.	Costa Mesa, CA	92627	NEW	477	89	89	80	67	176	18.7%	5-12	52	58.4%	7	486	24							
3/21/2016	GG	2	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	NEW	427	162	162	144	63	215	37.9%	5-12	81	50.0%	18	477	50	35	4	27				
10/31/2016	GG	2	Anthony Elementary	15320 Pickford St.	Westminster, CA	92683	CUR	418	98		82	22	71	22.4%	5-12	48	49.0%	14	440	68	23	2	19	1	6		3
12/2/2016 &	GG	3	Anthony Elementary	15320 Pickford St.	Westminster, CA	92683	CUR	475	77		67	38	94	49.4%	5-12	45	58.4%	5									
11/1/2016	MA	4	Baden Powell Elementary	2911 W. Stonnybrook Dr.	Anaheim, CA	92804	CUR	661	207		186	66	209	31.9%	5-12	125	60.4%	31	721	84	46	8	25	2	4	2	5
10/27/2016	TU	2	Benson Elementary	12712 Elizabeth Way	Tustin, CA	92780	CUR	380	126		85	37	105	29.4%	5-12	70	55.6%	17	393	58	42	11	3	5		4	
10/6/16 & 10/10/16	TU	5	Beswick Elementary	1362 Mitchell Ave.	Tustin, CA	92780	CUR	600	303		262	118	352	38.9%	5-12	183	60.4%	39	612	102	78	13	53	6	8	1	7
5/8,9 & 11/2017	AN	3	Betsy Ross Elementary	535 S. Walnut St.	Anaheim, CA	92802	CUR	928	179		166	60	159	33.5%	5-12	100	55.9%	12	1103	58	29	10	24	4	6		3
1/9/2017	GG	2	Brookhurst Elementary	9821 Catherine Ave.	Garden Grove, CA	92841	CUR	532	156		149	33	96	21.2%	5-12	100	64.1%	21	500	48	23	6	23	3	7	1	2
4/17&18 & 5/2,30/201 7	GG	4	Bryant Elementary	8371 Orangewood	Garden Grove, CA	92841	CUR	700	323		299	103	283	31.9%	5-12	207	64.1%	23	733	126	72	7	42	11	22		2
5/16 & 5/22/2017	CE	2	Buena Terra Elementary	8299 Holder St.	Buena Park, CA	90620	CUR	530	137		120	18	70	13.1%	5-12	62	45.3%	7	544	4	2	1		1			
3/7,9,10, & 13/2017	GG	4	Clinton Elementary	13641 Clinton St.	Garden Grove, CA	92843	CUR	651	215		185	50	149	23.3%	5-12	115	53.5%	16	684	77	50	1	35	6	12		2
6/2/2016	NM	2	College Park Elementary	2380 Notre Dame Rd.	Costa Mesa, CA	92626	NEW	575	87	87	78	34	79	39.1%	5-12	52	59.8%	8	546	29	25	2	10	4	3	1	1
9/29/2016	GG	3	Cook Elementary	9802 Woodbury Ave.	Garden Grove, CA	92844	CUR	353	178		167	82	221	46.1%	5-12	98	55.1%	16	367	101	30	2	13	1	5		
4/10,11,14/ 2017	SA	3	Davis Elementary	1405 French St.	Santa Ana, CA	92701	CUR	639	203		182	66	170	32.5%	5-12	159	78.3%	28	557	110	1	1	41	6	18		

Back to Agenda

Back to Item

2/6/17 & 2/7/17	SA	3	Diamond Elementary	1450 S. Center St.	Santa Ana, CA	92704	CUR	542	238		218	45	153	18.9%	5-12	166	69.7%	31	547	35	45	5	19	9	20			
12/12/16 & 12/3/17	MA	4	Disney Elementary	2323 W. Orange Ave.	Anaheim, CA	92804	CUR	659	138		224	75	246	54.3%	5-12	138	100.0%	21	666	128	15	4	18	2	5	1	1
5/15/2017	CE	1	Dysinger Elementary	7770 Camellia Dr.	Buena Park, CA	90620	CUR	480	181		173	14	47	7.7%	5-12	105	58.0%	11	491	44	27	7	2	1	9		4
4/23/2016	AN	2	Edison Elementary - Tracks A&B	1526 E. Romneya	Anaheim, CA	92805	CUR	494	117		111	38	83	32.5%	5-12	74	63.2%	17	250								
5/20/2016	AN	2	Edison Elementary (Tracks C&D)	1526 E. Romneya	Anaheim, CA	92805	CUR	414	101		94	25	83	24.8%	5-12	71	70.3%	11	265	62	91	8	20	4	10	8	3
11/3/16 & 11/4/16	TU	4	Estock Elementary	14741 North B Street	Tustin, CA	92780	CUR	640	289		259	76	192	26.3%	5-12	179	61.9%	27	673	119	81	8	28	4	13	1	4
12/15/2016	TU	1	Estock Elementary (Add'l Sealant Day)	14741 North B St.	Tustin, CA	92780	CUR					44	94	#DIV/0!	5-12		#DIV/0!										
1/10/2017	GG	3	Faylane Elementary	11731 Morrie Lane	Garden Grove, CA	92840	CUR	610	172		157	55	186	32.0%	5-12	104	60.5%	18	550	64	11	6	18	2	1		2
11/17/2016	TU	2	Foss Elementary	18492 Vanderlip Ave.	Santa Ana, CA	92705	CUR	460	131		120	43	121	32.8%	5-12	78	59.5%	11	476	65	31	2	10		2	2	1
9/15/16 & 9/20/16	AN	4	Franklin Elementary (Anaheim)	521 W. Water St.	Anaheim, CA	92805	CUR	855	316		291	121	325	38.3%	5-12	186	58.9%	38	862	121	89	13	33	2	5	3	8
10/20/15 & 10/25/16	SA	5	Franklin Elementary (Santa Ana)	210 W. Cubbon St.	Santa Ana, CA	92701	CUR	450	205		186	92	244	44.9%	5-12	131	63.9%	27		61	70	9	19	1	3	2	1
1/23 & 26/2017	GG	2	Gilbert Elementary	9551 Orangewood Ave.	Garden Grove, CA	92841	CUR	543	146		138	30	91	20.5%	5-12	99	67.8%	18	580	73	11	2	13	1	3		1
3/13,14,16 & 4/11/2017	SA	4	Glenn Martin Elementary	939 W. Wilshire Ave.	Santa Ana, CA	92707	CUR	698	311		297	142	311	45.7%	5-12	191	61.4%	34	673	125	69	4	31	3	16		3
3/27,28,31/ 2017	SA	3	Harvey Elementary	1635 S. Center St.	Santa Ana, CA	92704	CUR	455	158		146	35	104	22.2%	5-12	121	76.6%	19	469	75	54	6	31	2	14		1
10/24/16 & 10/27/16	GG	4	Hazard Elementary	4218 W. Hazard Ave.	Santa Ana, CA	92703	CUR	545	238		217	71	227	29.8%	5-12	140	58.8%	32	567	142	63	10	21	2	4	2	1
11/8/16, 11/14/16 & 11/15/16	TU	5	Heideman Elementary	15571 Williams St.	Tustin, CA	92780	CUR	650	326		292	56	172	17.2%	5-12	177	54.3%	32	620	105	85	7	22	2	11	1	6
1/6/2017	TU	1	Heideman Elementary (Add'l Sealant Day)	15571 Williams St.	Tustin, CA	92780	CUR					45	132	#DIV/0!	5-12		#DIV/0!										
4/19/2017	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	541	134		124	79	189	59.0%	5-12	81	60.4%	7	585	98	32		24	3	16		2
4/20 & 4/24/2017	GG	3	Heritage Elementary	426 S. Andres Place	Santa Ana, CA	92704	CUR	541	130		118	63	160	48.5%	5-12	50	38.5%	10									
12/15/16 & 12/18/16	GG	2	Hill Elementary	9681 11th St.	Garden Grove, CA	92844	CUR	370	137		116	34	83	60.6%	5-12	80	58.4%	16	375	18	25	2	22		6	3	
3/7/2016	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	990	269		258	93	296	34.6%	5-12	187	69.5%	23	851	79	170	28	70	20	37	13	6
4/24,25,27/ 2017	SA	3	Jackson Elementary	1143 S. Nakoma Dr.	Santa Ana, CA	92704	CUR	925	243		218	88	235	36.2%	5-12	152	62.6%	25	933								
10/18/16 & 10/20/16	GG	3	Lawrence Elementary	12521 Monroe	Garden Grove, CA	92841	NEW	600	188	188	162	52	180	27.7%	5-12	137	72.9%	29	599	80	62	5	17		7		2
4/6/2017	CE	2	Los Coyotes Elementary	8122 Moody St.	La Palma, CA	90623	CUR	535	262		236	47	157	17.9%	5-12	43	16.4%	4	540	49	21		33	1	8		2
1/12/17 & 1/17/17	MA	4	Low Elementary	215 N. Ventura St.	Anaheim, CA	92801	CUR	635	188		178	85	231	45.2%	5-12	96	51.1%	26	634	61	29	10	16	5	9	3	3
4/13,14,18, 21 & 9/8/16 &	SA	5	Lowell Elementary	700 S. Flower St.	Santa Ana, CA	92703	CUR	844	319		286	145	431	45.5%	5-12	165	51.7%	46	861	126	70	8	36	2	16		4
9/22/16	AN	4	Mann Elementary	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	876	133		124	53	142	39.8%	5-12	90	67.7%	18		83	72	6	27	3	5	6	3
8/25/2016	AN	2	Mann Elementary - Tracks A&B	600 W. La Palma Ave.	Anaheim, CA	92801	CUR	438	100		83	19	43	19.0%	5-12	68	68.0%	14	727								
10/17/2016 & 11/8/16	MA	4	Marshall Elementary	2627 Crescent Ave.	Anaheim, CA	92801	CUR	700	251		226	77	218	30.7%	5-12	139	55.4%	23	736	130	61	5	13	4	11	2	2
1/17/2017	GG	2	Marshall Elementary	15791 Bushard Ave.	Westminster, CA	92683	CUR	414	169		158	31	109	18.3%	5-12	117	69.2%	23	423	61	23	4	11	2	4	2	1
12/1/16 & 12/9/16	MA	5	Maxwell Elementary	2613 W. Orange Ave.	Anaheim, CA	92804	CUR	822	228		213	66	183	28.9%	5-12	142	62.3%	29	857	70	28	4	32	2	10	2	1
5/1,4, & 5/2017	CE	3	Miller Elementary	7751 Furman Rd.	La Palma, CA	90623	CUR	578	146		134	57	155	39.0%	5-12	51	34.9%	1	614	36	18	3	20		6		4
1/19/17 & 1/31/17	GG	4	Mitchell Elementary	13451 Taft Ave.	Garden Grove, CA	92843	CUR	453	181		170	30	71	16.6%	5-12	122	67.4%	23	471	87	14	6	18		3	2	
11/7/2016	TU	2	Nelson Elementary	14392 Browning Ave.	Tustin, CA	92780	CUR	545	155		137	35	112	22.6%	5-12	74	47.7%	14	562	53	29	3	19		4	1	3
1/27/2017	GG	3	Newhope Elementary	4419 West Regent Dr.	Santa Ana, CA	92704	CUR	411	123		113	51	168	41.5%	5-12	41	33.3%	6	420	33	4	3	6	1		1	1
10/25/2016	AN	2	Orange Grove Elementary	1000 S. Harbor Blvd.	Anaheim, CA	92805	NEW	690	120	120	108	23	65	19.2%	5-12	67	55.8%	18	681	33	38	8	15	1	3	3	3
2/14/2017	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	520	119		115	15	60	12.6%	5-12	78	65.5%	7	549	11	47	3	27	4	25		1
3/24 & 3/29/2017	GG	2	Parkview Elementary	12272 Wilken Way	Garden Grove, CA	92840	CUR	500	106		93	38	98	35.8%	5-12	58	54.7%	6									

Back to Agenda

Back to Item

Back to Agenda

Back to Item

3/20,21,23, 30,31/2017; 4/3,4,20/20 17	GG	8	Peters Elementary	13162 Newhope St.	Garden Grove, CA	92843	CUR	1290	559		509	164	464	29.3%	5-12	324	58.0%	40	1302	199	125	8	94	14	44		5
8/27/17 & 2/28/17	SA	3	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	600	237		226	50	163	21.1%	5-12	173	73.0%	29	618	8	74	4	36	4	32	2	2
2/2/2017	SA	1	Pio Pico Elementary	931 W. Highland St.	Santa Ana, CA	92703	CUR	600				50	167	21.1%	5-12		#DIV/0!										
3/13/2016	NM	3	Pomona Elementary	2051 Pomona Ave.	Costa Mesa, CA	92627	CUR	512	265		212	67	206	25.3%	5-12	139	52.5%	15	523	90	70	7	29	5	18	1	1
9/1/16 & 9/19/16	AN	5	Ponderosa (Tracks C&D)	2135 S. Mountain View Ave.	Anaheim, CA	92802	CUR	530	313		279	125	338	39.9%	5-12	203	64.9%	39	552	148	152	29	71	15	13	9	5
8/26/2016	AN	2	Ponderosa Elementary - A&B	2135 S. Mountain View Ave.	Anaheim, CA	92802	CUR	530	177		162	57	129	32.2%	5-12	116	65.5%	28	530								
6/6/2016	GG	4	Post Elementary	14641 Ward Street	Westminster, CA	92683	NEW	536	236	236	220	88	330	37.3%	5-12	127	53.8%	24	562	214	58	7	58	4	15		4
2/16/17 & 2/17/17	GG	4	Post Elementary	14641 Ward St.	Westminster, CA	92683	CUR	520	224		201	76	217	33.9%	5-12	130	58.0%	16	526								
11/14/16 & 11/18/16	MA	3	Pyles Elementary	10411 S. Dale St.	Stanton, CA	90680	CUR	742	229		197	32	97	14.0%	5-12	117	51.1%	31	785	85	53	11	19		8	3	4
1/25/2017	MA	1	Pyles Elementary (Add'l Sealant Day)	10411 S. Dale St.	Stanton, CA	90680	CUR					21	77	#DIV/0!	5-12		#DIV/0!										
5/11,12 & 16/2017	CE	3	Raymond Temple Elementary	7800 Holder St.	Buena Park, CA	90620	CUR	540	198		174	44	139	22.2%	5-12	89	44.9%	18	569	22	12	4	8	3	2		3
22 & 24/2017	AN	5	Revere Elementary	140 W. Guinida Lane	Anaheim, CA	92805	CUR	871	299		278	138	397	46.2%	5-12	140	46.8%	21	941	98	54	2	40	4	21		5
2/21/17 & 2/24/17	GG	4	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	580	266		238	51	164	19.2%	5-12	174	65.4%	23	588	37	50	8	71	3	15		4
3/15/2017	GG	4	Riverdale Elementary	13222 Lewis St.	Garden Grove, CA	92843	CUR	550				30	90	11.3%	5-12		#DIV/0!										
2/23/17 & 2/24/17	GG	5	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	500	231		214	68	354	29.4%	5-12	142	61.5%	25	522	11	59	8	46	3	23	2	1
3/1/2017 & 3/21/17	GG	2	Rosita Elementary	4726 Hazard Ave.	Santa Ana, CA	92703	CUR	500				69	205	29.9%	5-12		#DIV/0!										
8/26/16 & 9/27/16	GG	5	Russell Elementary	600 S. Jackson St.	Santa Ana, CA	92704	CUR	690	301		281	102	329	33.9%	5-12	209	69.4%	51	628	112	114	7	22	6	9	11	3
11/29/16 & 12/1/16	MA	1	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	CUR	800	119		109			0.0%	5-12	67	56.3%	16	838	78	41	4	19		8	1	3
12/1/2016	MA	2	Salk Elementary	1411 S. Gilbert St.	Anaheim, CA	92804	CUR	849	85		81	66	195	77.6%	5-12	33	38.8%	7									
5/22 & 23/2017	CE	2	San Marino Elementary	6215 San Rolando Way	Buena Park, CA	90620	CUR	580	218		198	31	109	14.2%	5-12	105	48.2%	11	586								
10/1/2016	MA	2	Schweitzer Elementary	229 S. Dale Ave.	Anaheim, CA	92804	CUR	635	159		147	42	121	26.4%	5-12	124	78.0%	20	665	73	49	4	14	2	3	7	3
2/2/17 & 2/7/17	SA	3	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	CUR	415	188		168	48	111	25.5%	5-12	109	58.0%	24	424	59	22	6	17	1	4		1
3/1 & 3/2/2017	SA	1	Sepulveda Elementary	1801 S. Poplar St.	Santa Ana, CA	92704	CUR	415				19	46	10.1%	5-12		#DIV/0!										
3/6, 3/9 & 3/10/17 & 4/7/17 ,	GG	4	Simmons Elementary	11602 Steele Dr.	Garden Grove, CA	92841	NEW	453	222	222	206	57	182	25.7%	5-12	146	65.8%	25	445	103	59	2	38	4	25		
9/13/16, & 5/18,19,23 & 26/2017	AN	4	Sunkist Elementary	500 N. Sunkist St.	Anaheim, CA	92806	CUR	864	365		343	137	386	37.5%	5-12	230	63.0%	44	899	83	97	5	55	7	10	4	7
	GG	4	Sunnyside Elementary	9972 E. Russell Ave.	Garden Grove, CA	92844	CUR	665	227		199	74	219	32.6%	5-12	101	44.5%	21	683	8	5	2	2	1			
12/1/16 & 1/5/17	TU	6	Thorman Elementary	1402 Sycamore Ave.	Tustin, CA	92780	CUR	573	281		263	105	298	37.4%	5-12	179	63.7%	39	601	71	44	15	28	7	13	3	5
12/13/2016	TU	2	Tustin Ranch Elementary	12950 Robinson Dr.	Tustin, CA	92782	CUR	646	150		132	19	71	12.7%	5-12	63	42.0%	11	638	88	10	4	14		3		
12/8/16 & 1/30/17	TU	4	Veeh Elementary	300 South C St.	Tustin, CA	92780	CUR	432	170		164	63	181	37.1%	5-12	103	60.6%	17	451	58	21	9	24	2	3	2	2
4/3,4,25, & 27/2017	GG	4	Violette Elementary	12091 Lampson Ave.	Garden Grove, CA	92840	CUR	500	224		209	102	262	45.5%	5-12	125	55.8%	15	504	93	49	3	31	5	18		2
10/4/2016	GG	2	Wakeham Elementary	7772 Chapman Ave.	Garden Grove, CA	92840	CUR	344	100		79	33	110	33.0%	5-12	85	85.0%	22	343	43	38	6	9	2	3	2	1
12/6/16 & 1/10/17	MA	4	Walter Elementary	10802 Rustic Lane	Anaheim, CA	92804	CUR	624	161		144	47	125	29.2%	5-12	105	65.2%	15	658	70	24	2	11	5	7	1	
3/2,6,7 & 4/3/17	GG	5	Warren Elementary	12871 Estock Dr.	Garden Grove, CA	92840	CUR	488	212		203	99	270	46.7%	5-12	111	52.4%	18	530	72	154	3	36	2	27		
5/25,26 & 30/2017	SA	3	Washington Elementary	910 W. Anahurst Pl.	Santa Ana, CA	92704	NEW	823	153	153	128	58	174	37.9%	5-12	84	54.9%	12	825								
6/3/2016	NM	3	Wilson Elementary	801 W. Wilson St.	Costa Mesa, CA	92627	NEW	477	111	111	100	67	176	60.4%	5-12	12	10.8%	10	486	32	36	4	18	3	16	4	1
6/9/2016	SA	4	Wilson Elementary	1317 N. Baker St.	Santa Ana, CA	92706	CUR	720	294		266	133	266	45.2%	5-12	150	51.0%	33	749	88	73	8	39	4	16	14	1
1/26/2017	GG	2	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	CUR	410	92		84	26	68	28.3%	5-12	41	44.6%	5	440	64	17	2	23	3	5		

3/12,27,30/ 2017	GG	3	Woodbury Elementary	11362 Woodbury Rd.	Garden Grove, CA	92843	CUR	410	94		88	67	198	71.3%	5-12	41	43.6%	14									
		##						108,211	29,753	7,468	27,018	10,470	31,698	27.5%		16,125	54.2%	3,028	102,896	9,873	6,286	953	3,151	543	1,575	560	245
		##							27.5%	25.1%	90.8%	35.2%				54.2%		10.2%		33.2%	39.0%	5.9%	19.5%	3.4%	9.8%	3.5%	1.5%
																				5,351			29.2%	5.0%	14.6%	5.2%	2.3%
																				10,774							
																										24.5%	
																										13.1%	

Back to Agenda
Back to Item

					Target	New	Screenings
CC	225	34					
DI	569	29					
MA	448	24		1st	2	0	1492
BE	349	20		2nd	10	4	4023
ES	361	28		3rd	5	8	3091
WE	358	13		4th			
DA	642	38					
PA	538	36					
WA	347	21					
HE	632	23					
LO	911	36					
AN	466	24					
TH	570	21			17	12	8606
HA	679	40					
RE	678	28					
WES	594	34					
PE	1238	24					
HO	533	24					
TR	643	25					
CE	522	28					
LO	703	26					
RO	510	25					
BP	676	32					
BR	744	26					
	13936	659	14595				

Back to Agenda Back to Item

IGT 5 Requests for Proposal
1. Access to Children's Dental Services

Appl. ID #	Organization Name	Request ($)	Project Title	Proposed Partners	Project Description	Additional CalOptima Members Served	Initia Assessr
198	Coalition of Orange County Community Health Centers	$ 1,000,000	Mouths Matter: Establishing a Dental Home for All Children	• Families Together of Orange County (FQHC Look-Alike in Tustin and expanding to Anaheim) • Korean Community Services (FQHC Look-Alike in Buena Park) • North Orange County Regional Health Foundation (FQHC Look-Alike in Fullerton) • Serve the People (FQHC in Santa Ana) • Southland Integrated Services (FQHC in Garden Grove) • Anaheim Union High School District • Boys and Girls Clubs • Buena Park School District • Centralia School District • Fullerton School District • Hands Together • KidWorks • Lighthouse Community Centers • Project Access • Rancho Santiago Community College District • Santa Ana Unified School District • The Cambodian Family • Tustin Unified School District	Provide a dental home with a mobile dental unit equipped to provide pediatric preventive and restorative treatment, thereby completing the circle of dental care. This project will enable five federally qualified health centers (FQHC) and FQHC Look-Alikes to establish a dental home with regular and emergency care for children and families	9,000	
191	Healthy Smiles for Kids of Orange County	$ 1,000,000	Full Cycle Dentistry	• Smile Center in Garden Grove • Smile Clinic at CHOC Children's • Garden Grove Unified School District • Santa Ana Unified School District • Westminster Unified School District • Anaheim Unified School District • Buena Park Unified School District • La Palma Unified School District • Tustin Unified School District	Provide preventive (screenings, dental cleanings, fluoride, sealants) and restorative treatment (fillings and cavity treatment) to CalOptima children at schools, primary care clinics, and community sites. Children who require advanced restorative treatment (such as treatment	13,564	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Appointments of Member Advisory Committee and Provider Advisory Committee Chair and Vice Chair

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

Recommended Actions
The Member Advisory Committee (MAC) recommends the appointment of:

A. Christine Tolbert as the MAC Chair and Pamela Pimentel as the MAC Vice Chair, each for a two-year term ending June 30, 2022.

The Provider Advisory Committee (PAC) recommends the appointment of:

A. Junie Lazo-Pearson, Ph.D. as the PAC Chair and John Nishimoto as PAC Vice Chair, each for a two-year term ending June 30, 2022.

Background
The CalOptima Board of Directors established the MAC and the PAC by resolution on February 14, 1995, to serve solely in an advisory capacity providing input and recommendations concerning the CalOptima program. The MAC is comprised of 15 voting members, including two standing members: one representative each from the Orange County Health Care Agency and the Orange County Social Services Agency. PAC is comprised of 15 voting members, including one standing member from the Orange County Health Care Agency.

Pursuant to Resolution Nos. 95-0214 and 20-0806, the CalOptima Board of Directors is responsible for the appointment of the MAC and PAC Chairs annually from among appointed members. The Chair may serve a two-year term.

Pursuant to Resolution Nos. 16-0804 and 20-0806, the CalOptima Board of Directors is responsible for the appointment of the MAC and PAC Vice Chairs annually from among appointed members. The Vice Chair may serve a two-year term.

Discussion
In the month leading up to the August 13, 2020 meeting, members of the MAC and PAC were asked to submit letters of interest for the Chair and Vice Chair positions to the Advisory Committees' staff. For the MAC, Christine Tolbert submitted a letter of interest for the Chair, and Pamela Pimentel submitted a letter of interest for the Vice Chair. At their August 13, 2020 meeting, MAC members voted to recommend Christine Tolbert as MAC Chair and Pamela Pimentel as the Vice Chair.

Back to Agenda

PAC members Junie Lazo-Pearson, Ph.D. submitted a letter of interest for the PAC Chair and John Nishimoto, O.D. submitted a letter of interest for the Vice Chair. At their August 13, 2020 meeting, PAC members voted to recommend Dr. Lazo-Pearson as the PAC Chair and Dr. Nishimoto as the PAC Vice Chair.

The recommended candidates for MAC Chair and Vice Chair are as follows with information from their letters of interest:

MAC Chair Candidate
Christine Tolbert*

Ms. Tolbert serves as the current Chair on the MAC and has represented Members with Special Needs since 2016 through consistent attendance at MAC meetings and several subcommittee and joint ad hoc meetings. Ms. Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for hundreds of individuals dealing with an extensive number of medical and/or special needs conditions. She has helped transition individuals from state hospitals into the community, assisting with their transition to managed care and accessing health care services.

MAC Vice Chair Candidate
Pamela Pimentel*

Ms. Pimentel has served on the MAC as the Children's representative since 2019 and is the current Vice-Chair of the MAC. For nine years, she served on the PAC representing the allied health, safety net, and nursing community and served as the PAC chair for several years prior to joining the MAC. Ms. Pimentel has worked with CalOptima since its start-up activities in 1993 and has participated in many of the town hall meetings held by the Board of Supervisors in 1991 and 1992 that led to the formation of CalOptima. During her 44-year nursing career, Ms. Pimentel has focused on serving some of the most vulnerable members of the community: pregnant moms and their babies.

The recommended candidates for PAC Chair and Vice Chair are as follows with information from their letters of interest:

PAC Chair Candidate
Junie Lazo-Pearson, Ph.D*

Dr. Lazo-Pearson has served on the PAC since 2018 as the Behavioral Health Representative where she has volunteered for several ad hoc committees during her tenure on the PAC. Dr. Lazo-Pearson is an Executive Advisor to Advanced Behavioral Health, Inc., a CalOptima contracted behavioral health group. As a result of her unique educational and work-related experiences, she has developed and maintained relationships with the constituents she serves. Currently, Dr. Lazo-Pearson is the Chair of Behavioral Services for providers of the Regional Center of Orange County, a position that requires her to lead and facilitate discussions during their monthly meetings.

PAC Vice Chair Candidate
John Nishimoto, O.D.*

*Indicates recommended candidates

Back to Agenda

Dr. Nishimoto has served as the PAC Chair since 2018 and has served on the PAC since 2016 as the Non-Physician Medical Practitioner Representative. A professor at Marshall B. Ketchum University and Southern California College of Optometry. Dr. Nishimoto is also a Senior Associate Dean for Professional Affairs at the Southern California College of Optometry and Marshall B. Ketchum University. He has active engagements with the leadership of the California Optometric Association (COA), the COA Health Care Delivery Systems Committee, and the leadership of the American Academy of Optometry and the California Academy of Physician Assistants. He is the Chair for the Board of Integrated Health Care Solutions, which included collaborative organizations such as Giving Children Hope and the Illumination Foundation.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Open nominations were held at the August 13, 2020, MAC and PAC meetings based on the letters of interest received. There were no additional nominations from the floor. The MAC and the PAC forwards the recommended Chairs and Vice Chairs to the Board of Directors for consideration and appointment.

Concurrence
Member Advisory Committee
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *08/26/2020*
Authorized Signature **Date**

*Indicates recommended candidates

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Recommended Appointment to the CalOptima Board of Directors' Member Advisory Committee

Contact
Belinda Abeyta, Executive Director, Operations, (714) 246-8400

Recommended Action
The CalOptima Member Advisory Committee (MAC) recommends:

Appointment of the following individual to serve a two-year term on the Member Advisory Committee, effective September 3, 2020: Kate Polezhaev to serve as the Consumer Representative for a term ending June 30, 2022.

Background
The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of 15 voting members. Pursuant to the resolution, the CalOptima Board appoints each member of the MAC for a two-year term, except for two standing seats: the Orange County Social Services Agency representative and the Orange County Health Care Agency representative, which have an unlimited term. The CalOptima Board is responsible for the appointment of all MAC members.

Discussion
Staff conducted a comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducting targeted community outreach to agencies serving Medi-Cal members, as well as posting recruitment materials on the CalOptima website. Staff also presented on the Board Advisory Committees at a Community Alliances Forum to enhance recruitment efforts.

The MAC Nominations Ad Hoc Subcommittee, composed of MAC committee members Maura Byron, Connie Gonzalez and Christine Tolbert, met on July 27, 2020, to evaluate the single applicant for the consumer seat. The MAC Nominations Ad Hoc recommended the proposed candidate be forwarded to the MAC for consideration.

At the August 13, 2020 MAC meeting, MAC members accepted the recommended candidate as proposed by the Nominations Ad Hoc and requested that the proposed candidate be forwarded to the CalOptima Board for consideration.

Back to Agenda

Candidate for the Consumer Representative position is as follow:

Consumer Representative Candidate
Kate Polezhaev

Kate Polezhaev is a current CalOptima Medi-Cal member and a full-time student at California State University, Fullerton. She is a California Certified Medical Assistant (CCMA) and is an active volunteer in the Anaheim community where she volunteers her time to assist others less fortunate.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy AA.1219a, the MAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the Committee. The MAC met to discuss the Ad Hoc Subcommittee's recommended candidate and concurred with the recommendation of the candidate. The MAC forwards the recommended candidate to the Board of Directors for consideration.

Concurrence
Member Advisory Committee Nominations Ad Hoc
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez — *08/26/2020*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 3, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

13. 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 expenditures for CalOptima's participation in the following community events:
    a. Up to $10,000 of CalOptima-branded promotional items for Santa Ana Unified School District (SAUSD) free COVID-19 Testing Events and school activities on or before June 2021; and
    b. Up to $10,000 at the Vietnamese Community of Southern California's Virtual 2020 Mid-Autumn Festival on Thursday, October 1, 2020;
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 community outreach and education benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Beginning on March 17, 2020, state and local agencies began implementing stay-at-home orders to limit professional, social and community gatherings outside of a list of "essential activities." As a result, CalOptima staff is not currently attending any-in person community events, health and resource fairs, town halls, workshops, or other public activities while the stay-at-home orders are in effect. Additionally, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19.

Back to Agenda

CalOptima staff recognizes the unprecedented health and economic challenges our community partners and members are experiencing due to the COVID-19 and understand the importance of supporting our community partners who are serving our members during this pandemic.

Discussion
The recommended actions are intended to provide CalOptima with opportunities to share information with current and potential members, increase access to health care services, meet the healthcare needs of our community, and develop and strengthen relationships.

a. **Santa Ana Unified School District Free COVID Testing Events and School Activities.** Staff recommends the authorization of expenditures for CalOptima branded hand sanitizers and bags to be distributed at SAUSD's Free COVID-19 Testing Events and school activities, which aligns with CalOptima's efforts to increase the community's awareness of COVID-19 testing and supports the public health guidelines to slow the spread of COVID-19. As of July 30, 2020, Santa Ana is listed as the city with the highest percentage of CalOptima members—nearly 18% (134,774) of CalOptima's total membership of 755,315. Additionally, Latino members represent nearly 45% (341,104) of CalOptima's total membership.

   In partnership with the County of Orange, Latino Health Access has been working with SAUSD to provide Free COVID-19 Testing Events at various school sites since early July to increase access to COVID-19 testing. These efforts have been made in response to high positivity rates among specific ethnic communities, including the Latino community. To date, SAUSD has hosted four COVID-19 testing events, which served an average of 250 people per event, for a total of 1,000 individuals tested. SAUSD plans to host additional COVID-19 testing events. CalOptima will also provide CalOptima information materials. These events are targeted to serve approximately 300 individuals per event and are scheduled to take place in the months of August, September and October, as needed. In addition, the promotional items and informational materials will be shared at other SAUSD school sites and other school sponsored events. For these events and activities, SAUSD is requesting 4,000 CalOptima-branded bags and 4,000 hand sanitizers. CalOptima staff will coordinate on-going distribution of these items as needed.

b. **Vietnamese Community of Southern California's Virtual 2020 Mid-Autumn Festival**. Staff recommends the authorization of expenditures for participation in the Vietnamese Community of Southern California's Virtual 2020 Mid-Autumn Festival which will be shared on social media and Vietnamese television on October 1, 2020. Also known as "Children's Day," this is a traditional festival for the Vietnamese community. The Mid-Autumn Festival celebrates three fundamental concepts of Gathering, Thanksgiving, and Praying. Children light lanterns and participate in a parade as part of the celebration.

   CalOptima has participated in this event for five years. Staff recommends CalOptima's continued support for this event with a $10,000 financial commitment for 2020, which includes the following: CalOptima name and logo on the stage's background throughout the event, thirty (30) mentions on stage, forty (40) radio impressions and twenty-five (25) television impressions. Past attendance for the in-person event was more 3,000 throughout

Back to Agenda

the day. This televised event will provide an opportunity to increase CalOptima's visibility in the Vietnamese community and may reach a larger audience given this virtual platform. This is an educational event that will allow outreach to the Vietnamese community and serve members speaking one or more of CalOptima's threshold languages, providing outreach to this under-served and hard to reach population.

Fiscal Impact

Funding for the recommended action of up to $20,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2020-21 Operating Budget that was approved by the Board on June 4, 2020.

Rationale for Recommendation

Staff recommends approval of the recommended actions in response to the COVID-19 pandemic as an opportunity to share information about CalOptima and the Medi-Cal program and the healthcare services CalOptima makes available in support of our community partners.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Request for CalOptima Branded Items
3. Sponsorship Request for Mid-Autumn Festival

/s/ Richard Sanchez *08/26/2020*
Authorized Signature **Date**

Back to Agenda

Attachment to the September 3, 2020 Board of Directors Meeting – Agenda Item 13

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Santa Ana Unified School District	1601 E. Chestnut Ave.	Santa Ana	CA	92705
Vietnamese Community of Southern California	P.O. Box 457	Garden Grove	CA	92842-2316

Back to Agenda Back to Item

Attachment 2: Santa Ana Unified School District Request

Per your request, below is additional information for SAUSD's request for CalOptima branded items.

The events and opportunities included below do not include dates as they are processes that SAUSD is currently engaging in, or will be engaging in, both through the re-opening of schools virtually or exploring a hybrid model at a later time. The donations that CalOptima provides will be distributed first through any free COVID testing model that SAUSD may be hosting and then equal amount of donations will be provided to all SAUSD schools to provide support through the following events/processes.

FREE COVID Testing at SAUSD School Sites
Since early July, SAUSD has partnered with Latino Health Access and the Orange County Health Care Agency to host free COVID testing at SAUSD school sites. Through the four events that have thus far been hosted, over 1,000 individuals have been tested. Moving forward, any testing date that is hosted via this partnership is targeted to serve about 300 individuals per event.

SAUSD Processes

- Re-opening of school sites, available at front offices for families to take with them
- Distribution of school materials or school supplies
- Points of contact between families and school sites

- Target population
  - Santa Ana families and students who interact with the school directly through the back to school processes or general school processes & community members who are testing for COVID.

- Item(s) requested and quantity

Item	**Quantity**
Plastic bags	4,000
Individual Hand sanitizer	4,000

- Overview of past events
  - SAUSD, in partnership with LHA, has hosted various free COVID testing dates. These COVID testing dates have been attended by an average of 250 people (maximizing the number of appointments and tests available). Thus far, we have hosted five testing dates. Each individual is provided with a bag that includes hand sanitizer, mask, and educational resources.
  - SAUSD back to school and school processes take place in an on-going timeline. Families interact with the school for a variety of reasons and some of this is by physically having contact with the school site. Each school site will engage in different processes and opportunities (while maintaining the recommended safety protocols). The number of attendees will vary but there are consistent points of contacts with schools.
- How the CalOptima items will be used
  - Items from CalOptima will be used to share resources with families (including educational materials around COVID and CalOptima) around COVID and by providing the hand sanitizer, providing them with a resource to keep safe and healthy.

It is our goal to share with families prevention information and resources regarding COVID, while also addressing resources about Medi-Cal and CalOptima.

MARTHA RIVERA, ED.M.

Coordinator, Family and Community Engagement (FACE)

martha.rivera@sausd.us
657-308-5197
1601 E. Chestnut
Santa Ana, CA 92701

VIETNAMESE COMMUNITY OF SOUTHERN CALIFORNIA
CỘNG ĐỒNG VIỆT NAM NAM CALIFORNIA
Domestic Non-Profit Corporation C1479500 • EIN 33-0448822 • Founded 1990
P.O. Box 457 • Garden Grove, CA 92842-2316
Email: contact@vncsc.org • Website: www.vncsc.org
Tel. (714) 248-6191

August 21, 2020

Mr. Richard Sanchez
CEO
CalOptima
505 City Parkway West
Orange, CA 92868

Re: Sponsorship for the televised 2020 Virtual Mid-Autumn Festival – Thursday, October 1, 2020

Dear Mr. Sanchez:

Thank you for your continued support of the Mid-Autumn Festival held annually at Mile Square Park in Fountain Valley. As you might remember the last event had approximately 3,000 attendees throughout the day and was a great success.

The Mid-Autumn Festival is a festival for the Vietnamese community also known as "Children's Day". Traditionally, the Mid-Autumn Festival celebrates three fundamental concepts: Gathering, Thanksgiving, and Praying. During this time, various activities are held to celebrate, such as harvesting rice before the 15th of the eight lunar months, provide offerings to the God of Earth, setting up platforms with light lanterns during the evening. The Mid-Autumn Festival is a day where families gather and enjoy time with their children. The tradition of brightly lit lanterns lends to the legend that Cuoi floated to the moon on a banyan tree and was stranded there. Children light lanterns and participate in a procession to show Cuoi the way back to Earth.

This year, due to COVID-19, we will be the hosting the first ever Virtual Mid-Autumn Festival. It will be televised on Thursday, October 1, 2020. Families will be able to celebrate this traditional holiday from home.

We would like to ask CalOptima's sponsorship in the amount of $10,000 for this year's 2020 Virtual Mid-Autumn Festival.

Your contribution can definitely make a difference and we are looking forward to building a successful partnership with your company. All any additional information, please feel free to contact us at:

Vietnamese Community of Southern California (VNCSC)
P.O. BOX 457, Garden Grove, CA 92842
Phone number: (714) 248-6191, Email: vncsc1990@gmail.com

Sincerely,

Nelson Nguyen,
VP of External Affairs

Back to Agenda Back to Item

VIETNAMESE COMMUNITY OF SOUTHERN CALIFORNIA
CỘNG ĐỒNG VIỆT NAM NAM CALIFORNIA
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MOON FESTIVAL 2020

October 1st, 2020, Pre-recorded event
It will be on social media and Vietnamese Television at 7pm

SPONSORSHIP PACKAGES

DIAMOND SPONSOR $10,000
Company logo display on Stage's background screen through-out the event
Thirty (30) mentions on stage
Forty (40) radio impressions
Twenty-five (25) Television impressions

GOLD SPONSOR $7,000
Company logo display on Stage's background screen Fifteen (15) times
Twenty (20) mentions on stage
Twenty-five (25) radio impressions
Fifteen (15) television impressions

SILVER SPONSOR $3,500
Company logo display on Stage's background screen Five (5) times
Ten (10) mentions on stage
Fifteen (15) radio impressions

BRONZE SPONSOR $1,000
Company logo display on Stage's background screen Moon Festival (1 time)
Five (5) mentions on stage

OPTIONAL:

1) Company logo display on Stage's background screen Moon Festival (1 time) $350

*Sponsorship packages subject to modifications without notice

Back to Agenda Back to Item

Board of Directors Meeting
September 3, 2020

Member Advisory Committee (MAC) Update

August 13, 2020 MAC Meeting

On August 13, 2020 the Member Advisory Committee (MAC) held its monthly meeting via GoTo Webinar and welcomed new members Melisa Nicholson, representing Foster Children, and Steve Thronson, as the Orange County Health Care Agency (OCHCA) Representative who were both appointed by the Board at the June 4, 2020 Board meeting.

The committee recommends the reappointment of Christine Tolbert as the MAC Chair and Pamela Pimentel as Vice Chair. If approved by the Board, both would serve a two-year term. The committee also recommended the appointment of Kate Polezhaev for the Consumer Representative seat

Richard Sanchez, Interim Chief Executive Officer, discussed potential rate adjustments with the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicare Services (CMS).

Ladan Khamseh, Chief Operating Officer, updated the committee on the Qualified Medicare Beneficiaries (QMB) program outreach.

Michelle Laughlin, Executive Director, Provider Network Operations provided a brief report on the Health Network Certification that is now required by DHCS.

David Ramirez, M.D., Chief Medical Officer, discussed the on-going COVID 19 pandemic and noted that the testing capacity for Orange County has increased. Dr. Ramirez updated the committee on the Pharmacy Carve-out plan that will transition to DHCS on January 1, 2021.

MAC also received a Homeless Health Initiative update, a Federal and State Legislative update and an annual HEDIS update.

MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's current activities.

Back to Agenda

Board of Directors Meeting
September 3, 2020

Provider Advisory Committee (PAC) Update

August 13, 2020 PAC Meeting

On August 13, 2020, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using Goto Webinar technology. The PAC welcomed new members Alpesh Amin, M.D., Alexander Rossel and Christy Ward, who were appointed by the CalOptima Board of Directors (Board) at the June 4, 2020 Board meeting. The new members' terms began on July 1, 2020.

PAC members voted and approved a recommendation to appoint Junie Lazo-Pearson, Ph.D as the new PAC Chair and John Nishimoto, O.D. as the new Vice Chair. If approved by the Board, both would serve two year terms.

Richard Sanchez, Interim Chief Executive Officer, provided a CEO report and discussed possible upcoming rate cuts.

In the area of CalOptima Operations, Ladan Khamseh, Chief Operating Officer, discussed the Qualified Medicare Beneficiary (QMB) program. Michelle Laughlin, Executive Director, Provider Network Operations, provided a brief report on network certification.

David Ramirez, M.D., Chief Medical Officer, discussed the ongoing COVID 19 pandemic and updated the PAC on the Health Homes Program, Hospital Data Exchange, and virtual care/telehealth options available to CalOptima members.

PAC also received a Homeless Health Initiative update and a Federal and State Legislative update.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

Back to Agenda

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CalOptima

Better. Together.

COVID-19 Update

Board of Directors Regular Meeting

September 3, 2020

David Ramirez, M.D., Chief Medical Officer

Emily Fonda, M.D., Deputy Chief Medical Officer

Miles Masatsugu, M.D., Medical Director

Brigette Gibb, Executive Director of Human Resources

Back to Agenda

Clinical Update

David Ramirez, M.D., Chief Medical Officer
Emily Fonda, M.D., Deputy Chief Medical Officer
Miles Masatsugu, M.D., Medical Director

Back to Agenda

CalOptima
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COVID-19 Status as of August 12

	CA	OC	OC Homeless	CalOptima	CalOptima LTC
Cases	586,056	41,823	141	2,614	965
Deaths	10,648	745	1	208	186
Recovered Cases		32,218		1,231	391
PCR Tests	9,303,467	504,559			

Back to Agenda

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COVID-19 Impact in Orange County

- Significant short- and long-term impact locally
  - Continued social distancing efforts
  - Decreased but continued spread of the virus in the community
  - Vulnerable populations continue to be impacted disproportionately
- Expanded testing
  - Multiple options have been implemented throughout Orange County
  - Delays in testing turnaround times are an ongoing challenge
- Economic impact
  - Anticipated increase in Medi-Cal and CalOptima membership
  - State budget revision

Back to Agenda

CalOptima
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Initial COVID-19 Impact on CalOptima

Member Experience

- Cancelling appointments because they are afraid to go out
- Requesting locations of testing sites
- Asking about coverage for COVID-19
- Complaining that their providers do not have testing available
- Complaining their providers won't see them due to COVID-19 outbreak
- Inquiring about providers who do telehealth visits due to anxiety of going in person
- Experiencing delays in care due to adjusted hours, rescheduled or cancelled appointments, e.g., not able to obtain durable medical equipment or medications, and not able to access provider, etc.

Provider Experience

- Changing hours, consolidating services and sites
- Cancelling elective surgeries and procedures
- Changing to phone consultations/telehealth
- Experiencing confusion about testing sites and current testing strategy
- Enrolling in Medi-Cal (new providers) under emergency Department of Health Care Services (DHCS) process and seeing members at Medi-Cal rates
- Dealing with Provider Facility Site Reviews temporarily on hold due to COVID-19, impacting credentialing and triannual reviews

Back to Agenda

CalOptima
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CalOptima COVID-19 Response

- CalOptima Board Actions
  - April
    - Allocated funds for staff transition to temporarily telework
    - Increased health network capitation by 5%, April through June
    - Approved modified policies to support ongoing Community-Based Adult Services (CBAS) operations
    - Approved telehealth policy to align with regulatory changes and increase care options
    - Ratified contracts with virtual care expert and medical consultants
    - Approved program modifications: Homeless Clinic Access Program and Clinical Field Teams
    - Expanded the Post-Acute Infection Prevention Quality Initiative
    - Authorized unbudgeted expenditures for emergency purchases of personal protective equipment (PPE)

Back to Agenda

CalOptima
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CalOptima COVID-19 Response (cont.)

- CalOptima Board Actions (cont.)
  - May
    - Authorized funding to support Orange County Nursing Home COVID-19 Infection Prevention Team program in partnership with UC Irvine and Orange County Health Care Agency
    - Approved Virtual Care Strategy and Roadmap to include texting and eConsult vendors
    - Approved funding and contracting for PACE Without Walls
    - Authorized modifications to CalOptima's participation in and funding for community events, due to the pandemic

Back to Agenda

CalOptima
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CalOptima COVID-19 Response (cont.)

- CalOptima Board Actions (cont.)
  - June
    - Approved FY 2020–21 Budget that protects providers from 1.5% rate cut by the Department of Health Care Services (DHCS)
    - Authorized modification to Intergovernmental Transfer (IGT) grant agreements in response to the pandemic
    - Approved reimbursement of employee expenses for temporary telework
  - August
    - Ratify temporary operational changes at PACE regarding skilled home health services

Back to Agenda

CalOptima
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CalOptima COVID-19 Response (cont.)

- Operational changes
  - Formed an internal CalOptima COVID-19 response team
  - Coordinated response with county public health officials
  - Executed communication plan to reach all stakeholders
  - Changed pharmacy rules to address members' needs
  - Conducted educational outreach
    - Member call campaign
    - Educational videos
  - Expanded Behavioral Health support, with 24/7 call line, telehealth options, trauma-informed care training and care coordination
  - Implemented multiple COVID-19 tracking and reporting efforts to enhance measurement and analysis

Back to Agenda

CalOptima
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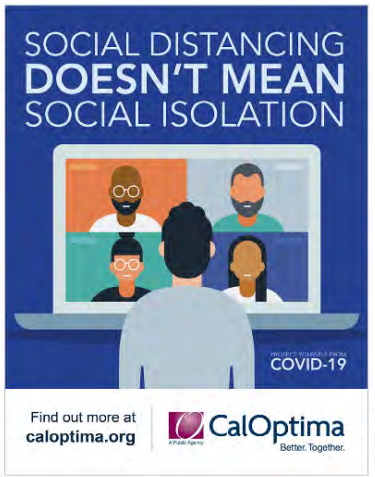
COVID-19 Community Awareness Campaign



Back to Agenda

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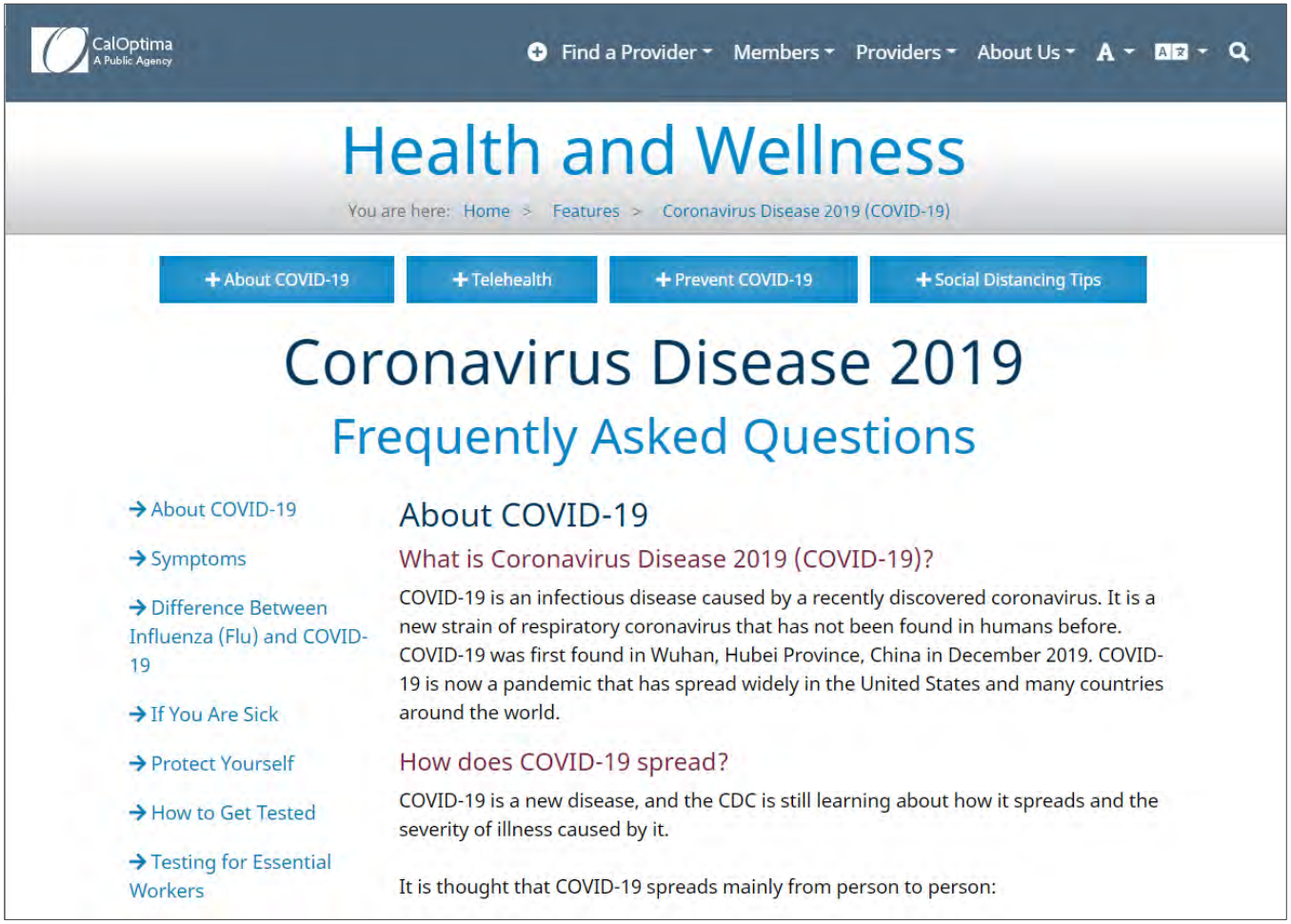
Member Web Page



Back to Agenda

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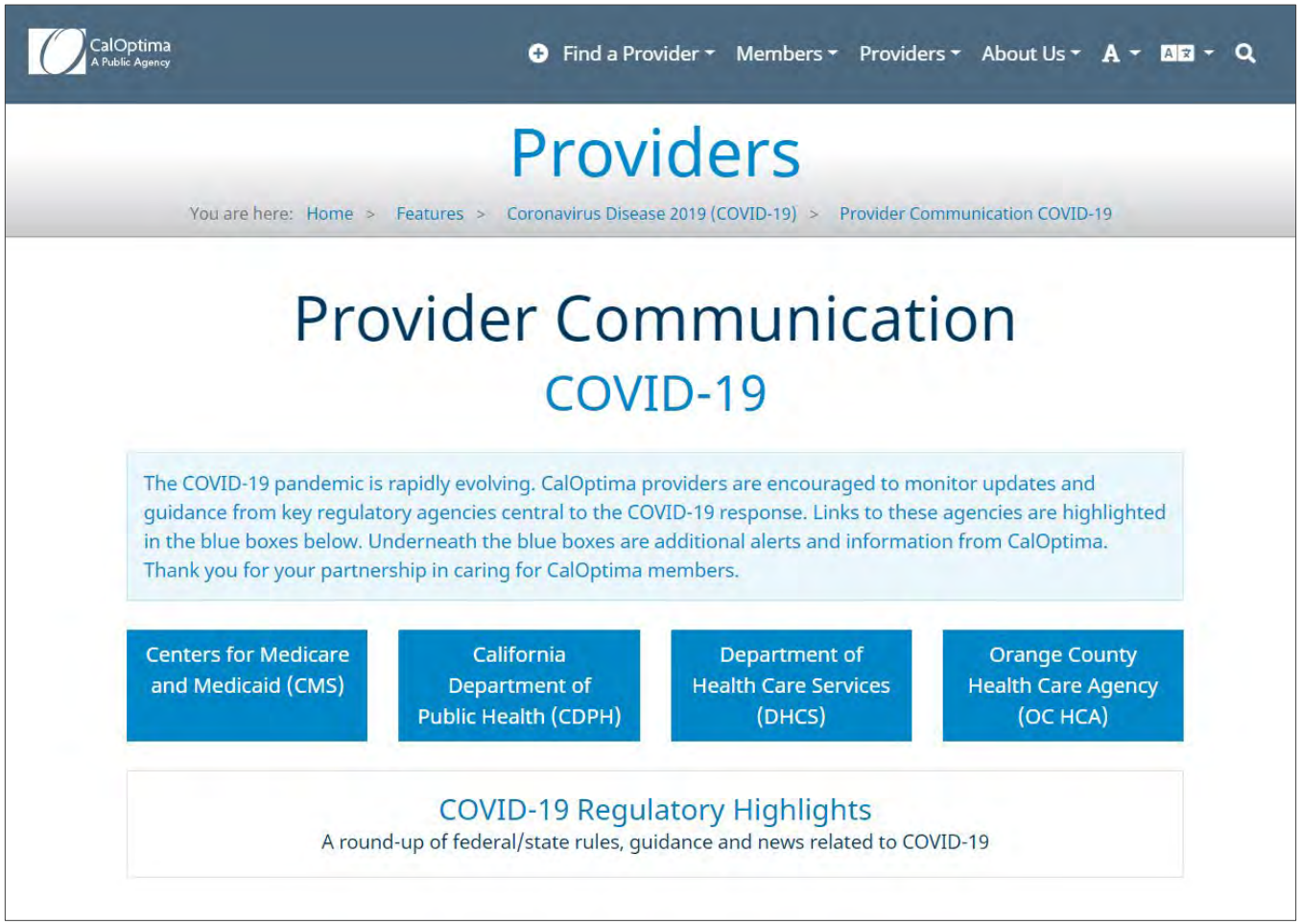
Provider Web Page



Back to Agenda

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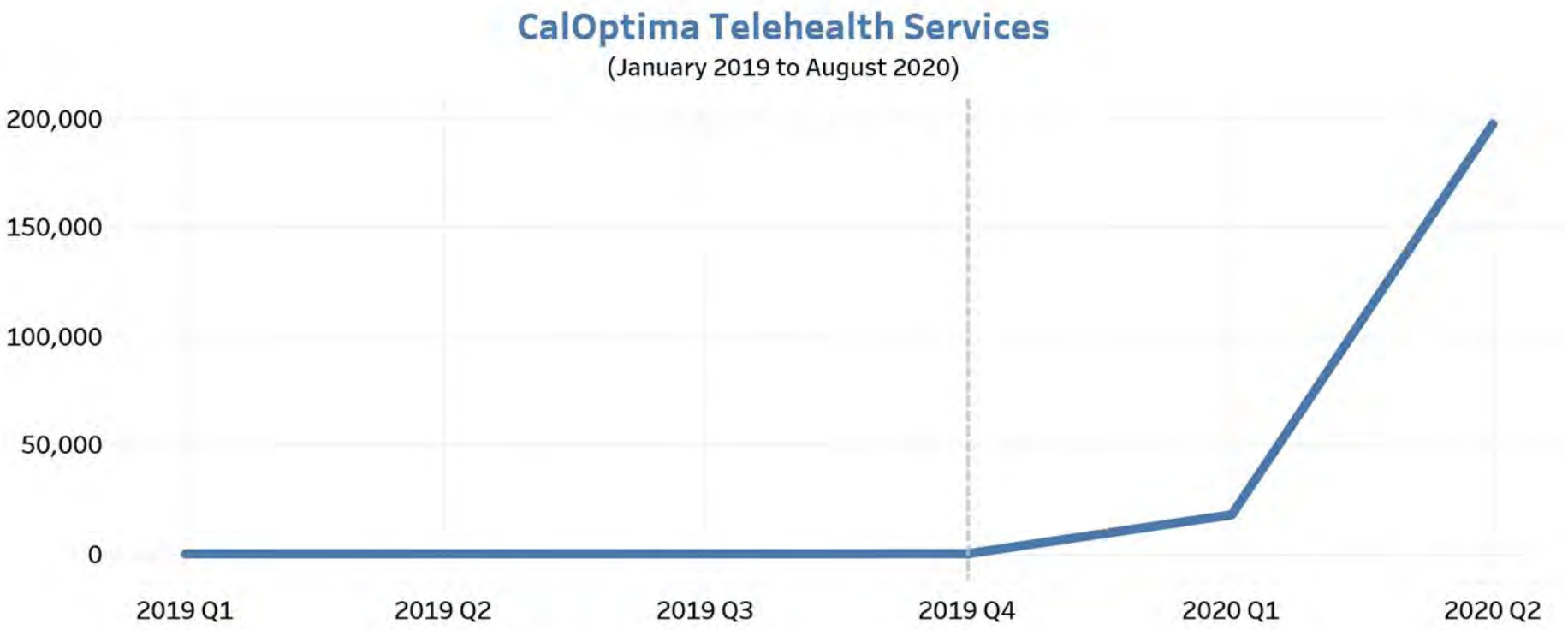
CalOptima Telehealth Services



Note: Based on claims and encounters received for full quarters

Back to Agenda

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Financial Support During COVID-19

Provider Type	Action
Health Networks	Pay up to $14 million, via 5% Medi-Cal capitation increase, from April to June 2020
Hospitals	Expedited more than $300 million in supplemental payments, including Hospital Quality Assurance Fee, directed payments and IGTs
Skilled Nursing Facilities	Approved 20% rate increase, totaling $1.6 million per year; expanded existing Post-Acute Infection Prevention Quality Incentive, adding $3.4 million for three years; and partnered with UC Irvine and Orange County Health Care Agency on COVID-19 infection prevention program, with $629,000 in funding
Community-Based Adult Services (CBAS)	Expanded covered services to include telehealth, meal delivery and other out-of-center services

Back to Agenda

CalOptima
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Orange County Nursing Home COVID-19 Infection Prevention Team

- CalOptima approved more than $629,000 for a comprehensive infection control training program in partnership with UC Irvine and the Orange County Health Care Agency
- Program launched June 1
  - All CalOptima-contracted nursing homes may participate and access the online toolkit
    - Videos and printable info available at www.ucihealth.org/stopcovid
  - 10 nursing homes have volunteered for intensive in-person training and video monitoring
- Goal is to boost the cultural change needed in an environment where there are multiple residents in a room, shared surfaces and limited social distancing

Back to Agenda

CalOptima
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Post-Acute Infection Prevention Quality Initiative (PIPQI)

- PIPQI supports the use of chlorhexidine (CHG) soap in place of regular liquid soap for bathing
  - Goal is to reduce the presence of multidrug resistant organisms, such as MRSA that are highly prevalent (up to 88%) on the skin of nursing home patients
- CalOptima recently increased funding and incentives to support the CHG protocol
  - An added benefit is that coronaviruses, such as COVID-19, are highly sensitive to CHG

Back to Agenda

CalOptima
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PACE Without Walls

- PACE Operations (facility-based to community-based)
  - Closed PACE center to all visitors; launched at-home model
  - Transitioned 76% of staff to telework
  - Secured PPE with active inventory management
  - Conducting daily screening of all on-site staff
  - Using mobile phlebotomy and imaging
- Wellness Calls
  - More than 11,000 calls since PACE Without Walls started
    - Calls range from 2–40 minutes
    - Calls serve as an important social outlet for participants and a way to monitor their wellbeing
  - Calls are conducted by nurses, personal care attendants, social workers and rehab therapists

Back to Agenda

CalOptima
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PACE Without Walls (cont.)

- Care Package Delivery
  - More than 1,500 care packages delivered to date, including toilet paper, activities, masks, cards and notes of support from the PACE team
  - PACE vans are taking participants grocery shopping and to drive-thru food banks, while contracted partners deliver prepared meals

Back to Agenda

CalOptima
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PACE Without Walls (cont.)

- On-Site Clinic
  - PACE clinic remains open for visits that cannot be done using telehealth
- Drive-Thru Clinics
  - For immunizations and other needs
- Virtual Care
  - PACE clinicians using tablets and cell phones to engage participants virtually
- Home-Based Services
  - Increase in provider home evaluations
  - Increase in skilled services provided in the home

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Back to Agenda

Next Steps

- Continue to coordinate response with the county health care agency
- Continue to monitor and follow county and state public health guidance
- Communicate any updates and changes to members, providers, health networks, staff and all other stakeholders

Back to Agenda

CalOptima
A Public Agency

Temporary Telework Update

Brigette Gibb, Executive Director of Human Resources

Back to Agenda

CalOptima
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COVID-19 and Temporary Telework

- In response to stay-at-home orders, social distancing requirements and other guidance intended to mitigate the spread of the coronavirus, CalOptima quickly but methodically deployed most of the workforce for temporary telework by April 2020

Work Location	Number of Employees	Totals
PACE	27	160
505 Building	133	
Temporary Telework	772	1,168
Regular Telework*	396	

*The maximum number of authorized regular teleworkers is 30% of approved full-time equivalent (FTE) positions. For FY 2020–21, the maximum is 449.

Back to Agenda

CalOptima
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Regular Telework Program

- Prior to the COVID-19 pandemic, CalOptima had a longstanding telework program, which is formalized in Policy GA.8044 – Telework Program

- Temporary teleworkers signed a temporary telework agreement that required them to adhere to the provisions of Policy GA.8044

Back to Agenda

CalOptima
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Telework Program Policy

- Among other provisions, Policy GA.8044 includes:
  - How telework positions are identified
  - Employee eligibility
  - Home office criteria
  - Adherence to CalOptima policies, rules, practices and more
  - Work schedule and accessibility requirements
  - Pre-deployment orientation requirements
  - Handling protected health information (PHI)
  - Performance management and monitoring

Back to Agenda

CalOptima
A Public Agency

Supporting Temporary Telework

- To support newly teleworking employees and their supervisors, Human Resources collaborated with other internal departments to:
  - Host *Engaging a Remote Workforce* webinar
  - Provide protected leave and/or ADA accommodations
  - Launch mandatory ergonomics (office environment) training
  - Develop four telework resource guides
    - Maintaining a Healthy Workspace Environment
    - What is Ergonomics?
    - Virtual Meeting Etiquette 101
    - Make Working From Home Work

Back to Agenda

CalOptima
A Public Agency

Supporting Temporary Telework (cont.)

- Establish monthly performance metrics and monitoring
- Share performance monitoring expectations with employees and leaders
- Begin completing workstation assessments and home checklists with all temporary teleworkers
- Fill the regular teleworker program to capacity (final deployment is scheduled for October)

- In October, CalOptima will conduct midyear reviews of every employee's performance, which will provide an opportunity for performance feedback and discussion after approximately six months of telework for most employees

Back to Agenda

CalOptima
A Public Agency

Continuing Temporary Telework

- While the pandemic is ongoing, CalOptima may likely continue temporary telework alongside regular telework and working inside CalOptima buildings

- Although a date to return temporary teleworkers to the office has not yet been identified*, a cross-departmental workgroup has been formed to plan for the eventual transition of employees out of temporary telework

* Individual exceptions are evaluated by HR and accommodated as needed.

Back to Agenda

CalOptima
A Public Agency

COVID-19 Workgroup

- Preparing CalOptima to accommodate more employees in buildings by:
  - Implementing COVID-19 mitigating health and safety measures
  - Updating policies and procedures
    - Behavioral expectations (e.g., wearing face masks, social distancing, symptom checking, etc.)
    - Signage (e.g., traffic flow, etc.)
  - Communicating expectations to employees
- Monitoring and assessing the ever-changing guidance surrounding COVID-19

Back to Agenda

CalOptima
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Considering Telework Expansion

- Leadership is evaluating the effectiveness and benefits of the past six months of temporary telework in order to consider a recommendation to expand the regular telework program

Back to Agenda

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Our Mission

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Back to Agenda

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

September 3, 2020

CalOptima Board of Directors Meeting

Emily Fonda, MD, MMM, CHCQM
Deputy Chief Medical Officer
Kris Gericke, Pharm.D.
Director, Pharmacy Management

Back to Agenda

Background

- Executive Order (EO) N-01-19 : Effective January 1, 2021, DHCS is “carving out” the pharmacy benefit for more than 11 million Medi-Cal beneficiaries from managed-care plans and moving it to the fee-for-service (FFS) program
- Only applies to Medi-Cal program (OC/OCC/PACE are not affected)
- “Medi-Cal Rx” is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered through the FFS delivery system
- DHCS has stated there will be no change to the January 1, 2021, Medi-Cal Rx implementation date

Back to Agenda

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Medi-Cal Rx

- The State of California selected a Pharmacy Benefit Manager (PBM) vendor to administer the new pharmacy program
  - Magellan Rx
- Effective January 1, 2021, CalOptima Medi-Cal outpatient pharmacy claims will be processed through Magellan Rx instead of MedImpact (current PBM), and providers will have to follow the state “formulary” or Contract Drug List (CDL)
- MedImpact will be retained for OC/OCC/PACE

Back to Agenda

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Medi-Cal Rx (cont.)

- Many Medi-Cal Rx operational details are currently not yet finalized by an All Plan Letter (APL):
  - Grievance process
  - Transition policy
  - Scope of coverage
  - Plan-retained responsibilities

Back to Agenda

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Medi-Cal Rx (cont.)

- Medi-Cal activities covered by the new program include:
  - Claims processing for all pharmacy services billed by pharmacies through Magellan Rx:
    - Medications
    - Enteral nutrition products
    - Some medical supplies
  - Pharmacy cross-over claims
  - Pharmacy network administration
  - Pharmacy drug rebate administration
  - Prior authorizations
  - Customer Service (beneficiaries and providers)
  - Health plan coordination activities (Magellan Rx liaison)

Back to Agenda

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Medi-Cal Rx (cont.)

- CalOptima retained Medi-Cal responsibilities:
  - Member care coordination as defined by DHCS (includes interaction with Magellan liaison)
  - Oversee clinical aspects of pharmacy adherence
  - Provide disease and medication management
  - Processing and payment of all medications and supplies billed on medical and institutional claims (Physician Administered Drugs, such as chemotherapy)
  - Participation on the Medi-Cal Global Drug Utilization Review (DUR) Board and other DHCS pharmacy committees
  - All PACE and OneCare Connect Medi-Cal pharmacy benefits
  - Others to be determined (DHCS All Plan Letter pending)

Back to Agenda

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Medi-Cal Rx Benefits

- Potential financial savings to the State of California
  - Lower administrative costs
  - Consolidate drug purchasing power
  - Strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers
- Standard pharmacy benefit across the state
- Modernize many existing DHCS pharmacy support systems
- Pharmacy network that includes the majority of the state's pharmacies

Back to Agenda

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Medi-Cal Rx Risks

- 180-day transition period benefit may suddenly create high TAR (PA)* volume when it ends with medication delays
- Lack of timely and complete pharmacy data for plans (2-day lag time for Medication Review Tool)
- Negative impact on care coordination
- Confusion for members and providers
- Magellan training website is not yet fully operational.
- APL is not finalized

* Treatment Authorization Request/Prior Authorization

Back to Agenda

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Medi-Cal Rx Risks (cont.)

- Unknown quality of customer service
- Decrease in plan quality scores
- Net financial savings are not guaranteed to materialize
  - Higher administrative costs
  - Ability to drive market share for preferred drug use?
  - Supplemental rebates may not offset program costs

Back to Agenda

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Medi-Cal Rx Risks (cont.)

- Limited state Contract Drug List (formulary) requires a TAR (PA) for a number of common medications for which CalOptima did not require authorization
- TAR (PA) required for many common pediatric medications that do not currently require prior authorization from CalOptima

Back to Agenda

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Medi-Cal Rx Outstanding Issues

- Pharmacy-related Customer Service call process
  - If members have medication access issues after contacting Magellan Rx, Customer Service staff will triage cases to CalOptima Pharmacy Management to assist
  - CalOptima Pharmacy Management staff will contact providers, pharmacies and/or the Magellan Rx liaison to resolve issues
- CalOptima Pharmacy Management staff will have limited access to the Magellan Rx claims system and will not be able to perform overrides (e.g., hospital discharge)
- Member grievance process related to pharmacy access issues has not been finalized

Back to Agenda

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Medi-Cal Rx Outstanding Issues

- Whole-Child Model
  - Potential disruption to medication access for these medically fragile children due to this transition
  - Standard PBM prior authorization criteria and processes do not adequately address the unique needs of these children with serious medical conditions. (CalOptima had a special process with MedImpact to accommodate these children.)
  - Many suspension/liquid formulations and other common CCS medications are not on the CDL
  - CalOptima Pharmacy Management staff are working with CHOC management to propose changes to medication coverage post-carve out to DHCS — ongoing process
- Plan-retained clinical responsibilities have not been defined (pending All Plan Letter)

Back to Agenda

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Communication and Training: Members

- Members will receive three mailings
  - 90- and 60-day from DHCS
  - 30-day from CalOptima
- Members will receive 30-day phone calls from CalOptima
- Magellan Rx will not open their call center until January 1, 2021
- CalOptima Customer Service will be responsible for answering all calls regarding the carve out before January 1, 2021
- After the final APL draft with CS instructions, a script will be created for members who may call CalOptima first and get referred to Magellan

Back to Agenda

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Communication and Training: Providers

- Pharmacies will receive three mailings from DHCS (90-, 60- and 30-day)
- Providers can register for the DHCS Medi-Cal Rx Subscription Service (MCRxSS) for email updates:
  - https://mcrxsspages.dhcs.ca.gov/Medi-CalRxDHCScagov-Subscription-Sign-Up
- DHCS will provide training materials for Medi-Cal providers starting in September via the Magellan Medi-Cal Rx website:
  - https://medi-calrx.dhcs.ca.gov/home/

Back to Agenda

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Communication and Training: CalOptima

- A CalOptima Multi-Departmental Workgroup has been regularly meeting since December 2019 to coordinate activities related to the carve out
- CalOptima began sending out communications to health networks and providers in July 2020
- CalOptima included presentations about the carve out in Health Network Forums and other meetings (WCM-CAC, WCM-FAC, PAC, MAC, QIC)
- CalOptima staff continue to participate in Medi-Cal Rx stakeholder meetings
  - LHPC
  - CAHP
  - DHCS meetings and forums

Back to Agenda

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Back to Agenda

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Intergovernmental Transfer Overview

Board of Directors Meeting
September 3, 2020

Candice Gomez, Executive Director, Program Implementation

Back to Agenda

Intergovernmental Transfer (IGT)

- Background
- Funding Process and Partners
- CalOptima Total to Date
- Funded Projects
- COVID-19 Impact
- IGT 10 Status

Back to Agenda

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IGT Background

- CalOptima has participated in the Department of Health Care Services (DHCS) annual Rate Range IGT since 2010
- IGTs enable CalOptima and our governmental funding partners to receive additional revenue for services to Medi-Cal members
- IGT processes secure additional federal revenue to increase California's Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services to existing Medi-Cal members
  - IGTs 8–10: Funds must be used for Medi-Cal covered services included in CalOptima's DHCS contract for Medi-Cal members

Back to Agenda

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IGT Background (cont.)

- Contributions from eligible community funding partners can be matched through the IGT process up to upper rate range as established by the state's actuaries
- No guarantee of future availability of IGT funds
  - Best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries
- Board-approved spending plans are in place for IGTs 1–9

Back to Agenda

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IGT Funding Process

High-Level Steps:
1. CalOptima receives DHCS notice announcing IGT opportunity.
2. CalOptima secures funding partnership commitments.
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts.
4. Funding partners wire their contribution amount and additional 20% fee to DHCS.
5. CMS provides matching funds to DHCS.
6. DHCS sends total amount to CalOptima.
7. From the total amount, CalOptima returns each funding partner's original contribution.
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and, where applicable, retained amount for Managed Care Organization tax (IGT 1–6 only).
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees.

Back to Agenda

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Current IGT Funding Partners

- Children and Families Commission of Orange County
- Orange County Health Care Agency
- Orange Fire Department
- Newport Beach Fire Department
- University of California, Irvine

Back to Agenda

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CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic) March 2016 (MCE)**
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9	$43.96 million	April 2020
IGT 10*	TBD	TBD
Total Received	**$165.27 million**	

- Estimate; Pending DHCS Guidance ** Medi-Cal Expansion
- Determining unspent funds on closed projects is in progress

Back to Agenda

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IGT 1-7 Funded Projects

- Funds are available to provide enhanced benefits to existing Medi-Cal members
- Project examples include:
  - Internal initiatives
    - Personal Care Coordinators, member and provider portal, depression screenings, etc.
  - Recuperative care and medical respite services
  - Expand safety net services to support clinics to become Federally Qualified Health Centers
  - Community grants
    - Outpatient mental health services for children, integrate mental health into primary care, medication assistance treatment services, dental services, social determinants of health and food distribution
- Unused funds from closed initiatives may be reallocated by the board to other qualifying enhanced services

Back to Agenda

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IGT 8-9 Funded Projects

- Funds must be used for CalOptima Medi-Cal covered services for our Medi-Cal members, with any expenditures not qualifying as medical expenses counted by the state as part of CalOptima's administrative expenses
- Project examples include:
  - Expanded Office Hours for Member Access
  - Homeless Response Team
  - Hospital Data Exchange
  - Post Acute-Infection Prevention Quality Initiative

Back to Agenda

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IGT 5-7 COVID-19 Impacts

- Staff met with grantees to discuss impacts to their organization and grant deliverables
  - Heavily relying on virtual platforms, halt/decrease in routine care and increase in food and mental health services
  - On June 4, 2020, the Board of Directors approved
    - Eight requests for no-cost extension
    - Three requests for budget line item revisions
    - Two requests for temporary modifications in scope of work
  - Targeting submission of an additional no cost extension at the September 3, 2020, Board of Directors meeting

Back to Agenda

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IGT 10 Status

- On February 6, 2020, the Board of Directors approved CalOptima's pursuit of IGT 10 funding
  - Unlike prior IGTs, IGT 10 will cover an 18-month period
    - Rating period July 1, 2019–June 30, 2020 and July 1–December 31, 2020
    - Due to DHCS transition from fiscal to calendar year budget cycle
- Funder's contributions are estimated to be $78.6 million*
  - Funders must return final signed agreements to DHCS by September 2020
  - Two separate DHCS wire transfer requests anticipated between April–September 2021
- CalOptima's share is estimated to be $66 million*
  - CalOptima may receive funds after each rating period wire transfer

* Amounts may change based on actual enrollment and member mix.

Back to Agenda

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IGT 10 Next Steps

- Identify potential focus areas and initiatives
  - Consider member needs, opportunities to enhance Medi-Cal programs and supporting providers
  - Ensure alignment with 2020–2022 Strategic Plan identified priorities and objectives
- Engage stakeholders proposed allocation of IGT 10 funds
- Present final recommendations to the Board of Directors

Back to Agenda

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Back to Agenda

CalOptima
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Board of Directors Meeting
September 3, 2020

CalOptima 2017–2019 Strategic Plan Closure and 2020–2022 Strategic Plan Update

This document provides an overview of CalOptima's work in the area of strategic planning. CalOptima routinely develops three-year strategic plans through an extensive process that engages the Board of Directors, executive team, staff and community stakeholders. At the end of 2019, we completed our 2017‑2019 Strategic Plan, and a document summarizing the initiatives follows this memo. We are currently in the middle of the first year of our 2020‑2022 plan. A brief summary of that plan is below, along with links to the plan's full text and an associated Environmental Scan document.

2017–2019 Strategic Plan Closure

CalOptima's 2017–2019 Strategic Plan focused on three priority areas: Innovation, Value, and Partnerships and Engagement; and two building blocks: Workforce Performance and Financial Strength. At the February 7, 2019, CalOptima Board of Directors (Board) meeting, staff presented an Information Item on the Year 2 Progress Report. Due to the completion of this three-year Strategic Plan at the end of the 2019, CalOptima is providing the attached Final Report, closing the remaining identified initiatives. A few highlights from the final year include:

- *Be Well OC:* CalOptima provided an $11.4 million prepayment for services to CalOptima members at the first wellness hub in Orange County. When completed, the wellness hub will be a single location that offers a seamless continuum of mental health care from triage to treatment. In addition, CalOptima staff are providing support to the Be Well collaborative by co-leading two workgroups: Close Treatment Gaps and Improve Access, and Establish Community Wellness Hubs. These are two of the six workgroups established by Be Well OC to address high-priority areas identified as needing the most attention and improvement.
- *Delivery System Study:* Presented to the Board in multiple sessions during 2019, the study brings together information and data about health care delivery throughout the health care industry and within CalOptima's delivery model. The study results are to inform future options for delivery system structure and practices by CalOptima, its health networks and providers.
- *Member Portal:* CalOptima launched its member portal in April 2019 and now provides online access to information in English, Spanish and Vietnamese.

2020–2022 Strategic Plan Update

Across several months in 2019, Chapman Consulting facilitated the development of CalOptima's 2020–2022 Strategic Plan. The process included:

- Reviewing the Strategic Plans from 2017–2019 and prior years

Back to Agenda

- Conducting interviews with Board members and Executive staff
- Developing an Environmental Scan
- Facilitating meetings with key audiences
    - Full-day Board planning session
    - Joint meeting of CalOptima's Advisory Committees (Member Advisory Committee, OneCare Connect Member Advisory Committee, Whole-Child Model Family Advisory Committee and Provider Advisory Committee)
    - Meeting with health network representatives

The final 2020–2022 Strategic Plan builds on the achievements of the 2017–2019 Strategic Plan and identifies five Strategic Priorities:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

CalOptima's website includes postings of the 2020–2022 Strategic Plan approved at the December 5, 2019, Board meeting and the Environmental Scan.

Information about the Strategic Plan was shared with employees at all levels and is part of new employee orientation. The plan was also available to support the development of the Fiscal Year 2020–21 budget and the identification of new initiatives for employee goal setting. Staff is gathering information on the current and new initiatives that align with the five Strategic Priorities to enable ongoing monitoring and periodic updates to the Board.

The Strategic Plan was also shared in CalOptima's 2020 Report to the Community and presented during the January 2020 Community Alliance Forum, as well as meetings with the Orange County Health Improvement Partnership and the Coalition of Orange County Community Health Centers. These are the first steps to identifying synergies with other community organizations and developing support for CalOptima initiatives.

Next Steps

CalOptima is finalizing a workplan for implementing, monitoring and reporting progress on the 2020–2022 Strategic Plan. Progress reports on the 2020–2022 Strategic Plan will be provided to your Board on a semi-annual basis or as appropriate.

Attachments

1. 2017–2019 Strategic Plan Final Report
2. 2020–2022 Strategic Plan

Back to Agenda

Strategic Plan 2017–2019

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Final Report

January 1, 2017–December 31, 2019

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Back to Agenda

Strategic Plan Final Report

The CalOptima Strategic Plan 2017–2019 Final Report encapsulates achievements across three years in the priority areas of innovation, value, and partnerships and engagement. Our endeavors to improve members' health care are always in partnership with Orange County's community of providers, advocates and stakeholders. We have you and others to thank for supporting this plan.

Innovation at CalOptima primarily means integration, and the integration efforts of the past three years are significant. We brought mental and physical health benefits together by directly administering mild to moderate mental health services and Applied Behavior Analysis in Medi-Cal. CalOptima transitioned California Children's Services to the Whole-Child Model, creating a seamless program for more than 12,000 medically complex children. And we prepared to launch the Health Homes Program to support the highest-risk members with enhanced care coordination.

Value is about quality of care delivered relative to the cost. For the duration of the Strategic Plan, CalOptima maintained our record of top quality in Medi-Cal as measured by the National Committee for Quality Assurance. At the same time, we upheld our commitment to keeping administrative costs low and setting appropriate provider payments via rate rebasing and other efforts.

Partnerships and Engagement strengthen all efforts on behalf of members, especially in the areas of homeless health and our Program of All-Inclusive Care for the Elderly (PACE). Community health centers were essential partners in developing new programs for members experiencing homelessness, such as Orange County's first-ever Clinical Field Teams. And collaboration with Community-Based Adult Services centers enabled CalOptima PACE to expand capacity and serve participants in a new way.

With this plan now complete, CalOptima has transitioned to the 2020–2022 Strategic Plan. And already we know that this next three-year period will be dynamic and challenging based on the realities of the COVID-19 pandemic. In this unprecedented time, our strategic priorities may change according to the environment, but our values won't. CalOptima will continue to put members first and work Better. Together. with our community. Thank you!

Richard Sanchez
Interim Chief Executive Officer

Board of Directors

Paul Yost, M.D. (Chair)
Anesthesiologist, CHOC Children's and St. Joseph Hospital

Dr. Nikan Khatibi (Vice Chair)
Anesthesiologist/Pain Medicine Specialist, Riverside Medical Clinic

Ria Berger
CEO, Healthy Smiles for Kids of Orange County

Ron DiLuigi
Retired Health Care Executive

Andrew Do
Supervisor, First District, Orange County Board of Supervisors

Alexander Nguyen, M.D.
Psychiatrist, Harbor-UCLA Medical Center

Lee Penrose
Health Care Executive

Clayton Chau, M.D., Ph.D.
Director, Orange County Health Care Agency

J. Scott Schoeffel
Health Care Attorney

Michelle Steel
Supervisor, Second District, Orange County Board of Supervisors

Doug Chaffee (Alternate)
Supervisor, Fourth District, Orange County Board of Supervisors

Note: Board members listed above oversaw the 2017–2019 Strategic Plan. A new Board was seated as of August 4, 2020.

Back to Agenda

CalOptima Strategic Plan 2017–2019

Strategic Priorities

Innovation

Pursue innovative programs and services to optimize member access to care

1. **Delivery System Innovation**
   Use pay-for-performance programs, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.
2. **Program Integration**
   Implement programs that create an integrated service experience for members, including an integrated physical and behavioral health service model.
3. **Program Incubation**
   Incubate new programs or services that address unmet member needs in areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.

Value

Maximize the value of care for members by ensuring quality in a cost-effective way

1. **Data Analytics Infrastructure**
   Establish robust information technology infrastructure and an integrated data warehouse to enable predictive modeling, performance accountability and data-based decision making.
2. **Pay for Value**
   Launch pay-for-performance programs and quality incentive initiatives that encourage provider participation, improve clinical quality and member experience outcomes, and spread best practices.
3. **Cost-Effectiveness**
   Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.

Partnerships and Engagement

Engage providers and community partners in improving the health status and experience of members

1. **Provider Collaboration**
   Enhance partnerships with networks, physicians and the Provider Advisory Committee to improve service to providers and members, expand access, and advance shared health priorities.
2. **Member Engagement**
   Seek input from the Member Advisory Committee and CalOptima's diverse membership to better understand member needs, and implement programs that strengthen member choice and experience.
3. **Community Partnerships**
   Establish new organizational partnerships and collaborations to understand, measure and address the social determinants of health that lead to health disparities among vulnerable populations.
4. **Shared Advocacy**
   Use provider and community relationships to educate stakeholders about health policy issues, and promote the value of CalOptima to members, providers and the broader population of Orange County.

Back to Agenda

CalOptima Strategic Plan 2017–2019

Building Blocks

Workforce Performance

Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes

1. **Employer of Choice**
   Establish a feedback-rich culture to ensure accountability, optimize performance and retain high performers capable of advancing organizational objectives.
2. **Collaborative Culture**
   Drive collaboration to strengthen data-informed decision making, launch innovative member-centered programs and services, and evaluate shared performance.
3. **Operational Excellence**
   Review, measure and refine processes to ensure regulatory compliance, and pursue continuous improvement of programs and services for members.

Financial Strength

Provide effective financial management and planning to ensure long-term financial strength

1. **Strategic Goal Alignment**
   Ensure departmental budgets reinforce CalOptima's strategic priorities to advance the shared mission and values.
2. **Fiscal Management**
   Standardize the use of effective financial reporting and forecasting tools so directors develop sound departmental budgets, and promote a culture of transparency and accountability.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

January 1, 2017–December 31, 2019

✓ 2019	**Whole-Person Care (WPC) Pilot** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Integration* *Program Incubation*	Collaborated with DHCS, Orange County Health Care Agency and local stakeholders on the WPC Pilot. Participated in data exchange and provided personal care coordinators to better integrate care for members who are homeless and participating in WPC.
✓ 2019	**PACE Community-Based Primary Care Providers** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Developed a community-based primary care provider option whereby more than 30 PACE participants were able to receive primary care services in their home or in a community location.
✓ 2019	**Homeless Health** **Strategic Plan Elements:** Innovation *Program Incubation* Partnerships and Engagement *Member Engagement* *Community Partnerships*	Committed a $100 million to strengthen services and resources for Orange County's homeless population. Approved approximately $43 million for specific investments in recuperative care, medical respite care, a regional wellness campus, Clinical Field Teams, CalOptima's Homeless Response Team, homeless coordination at hospitals and a Homeless Clinical Access Program. Developed four guiding principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns.
✓ 2019	**Intergovernmental Transfers (IGTs)** **Strategic Plan Elements:** Innovation *Program Incubation* Financial Strength *Strategic Goal Alignment*	IGT 5: $11.4 million distributed for a regional wellness campus and $3.4 million in community grants. IGT 6/7: $10 million targeted for recuperative care and medical respite, and $20 million for community grants and internal projects. IGT 8: $43 million committed to Homeless Health Initiatives. IGT 9: Approximately $43 million allocated to support quality initiatives, such as expanded office hours, skilled nursing post-acute infection prevention, text messaging for members and other internal projects. IGT 10: Approximately $66 million in funding pending.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2019	**Proposition 56 Provider Payments** **Strategic Plan Elements:** Partnerships and Engagement *Provider Engagement*	Implemented enhanced funds distribution processes for improved internal and external efficiency.
✓ 2019	**Member Portal** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement*	Launched member portal with English, Spanish and Vietnamese access, providing members with mobile access to CalOptima information and services.
✓ 2019	**Electronic Provider Data Management** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* *Cost-Effectiveness* Workforce Performance *Collaborative Culture* *Operational Excellence*	Finalized the scope of work to engage a vendor that will support the development and implementation of web-based provider data management processes for providers, health networks and CalOptima. Vendor procurement is in progress.
✓ 2019	**Health Homes Program (HHP)** **Strategic Plan Elements:** Innovation *Program Integration* Partnership and Engagement *Member Engagement* *Provider Collaboration*	Launched HHP on January 1, 2020, offering enhanced care management for members with chronic conditions and substance use disorders (as of January 1) and for members with serious mental illness (as of July 1).
✓ 2019	**Delivery System Study** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Value *Cost-Effectiveness* Workforce Performance *Operational Excellence*	Completed the delivery system study and delivered the report to the CalOptima Board of Directors.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2019	**CalOptima Technical Assistance Program** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration*	Enrolled more than 625 clinical professionals in this program, which supports achieving meaningful use of electronic medical records. The state extended program to September 30, 2020.
✓ 2019	**Be Well OC** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Incubation* Partnerships and Engagement *Community Partnerships*	Completed a $11.4 million prepayment for services at the first Be Well OC wellness hub in Orange. Continuing to co-lead the Closing Treatment Gaps and Establishing Community Wellness Hubs workgroups and participating as a member of the Substance Use Disorder Leadership Group.
✓ 2019	**Dental Care Integration** **Strategic Plan Elements:** Innovation *Program Incubation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Explored opportunities to carve in dental benefits to CalOptima Medi-Cal but concluded that it isn't possible at this time. The California Dental Association and Orange County Dental Society are reluctant to endorse an integration pilot until results from the first pilot by Health Plan of San Mateo are available, but that pilot has not begun. Further, DHCS had proposed dental integration as part of the next federal waiver, which is now delayed until 2022.
✓ 2019	**CalOptima Foundation** **Strategic Plan Elements:** Financial Strength *Fiscal Management*	Completed the dissolution of the foundation and transferred the remaining funds back to CalOptima.
✓ 2019	**Employee Engagement Study** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* *Collaborative Culture*	Conducted a survey of employees to gain insight about the levels of engagement and workforce satisfaction. Created employee focus groups that made recommendations to executives about three areas needing improvement: employee voice, collaboration across departments and professional development. Some recommendations have been implemented and others will be addressed in the future.
✓ 2019	**Compensation Study** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* Financial Strength *Fiscal Management*	Completed a compensation study and presented findings to the Board twice. The Board did not approve the recommended actions.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2019	**Temporary Staffing Vendor** **Strategic Plan Elements:** Workforce Performance *Operational Excellence* Financial Strength *Fiscal Management*	Contracted and onboarded new temporary services vendors.
✓ 2019	**CalOptima Website** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Community Partnerships* Workforce Performance *Operational Excellence*	Redesigned www.caloptima.org to make it usable on mobile phones and more member-centric, as well as have a contemporary look and feel.
✓ 2019	**Technology Advancements** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* Workforce Performance *Operational Excellence*	Migrated email to Office 365 in the Microsoft cloud and adopted secure cloud technology. Implemented Mediture, a new electronic health record for PACE.
✓ 2019	**Whole-Child Model** **Strategic Plan Elements:** Innovation *Program Integration* Partnerships and Engagement *Provider Collaboration* *Member Engagement* *Community Partnerships*	Prepared the financial and operational changes needed to transition to Whole-Child Model (WCM) from California Children's Services (CCS). Collaborated with the Department of Health Care Services (DHCS), Orange County Health Care Agency, health networks, members, providers and other local stakeholders to share information and ensure no disruption in members' care. WCM was implemented on July 1, 2019, and initial feedback has been positive from families and providers alike.
✓ 2019	**Substance Use Disorders** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Incubation* Partnerships and Engagement *Provider Collaboration* *Member Engagement*	Implemented interventions at the prescriber and member level to curb opioid misuse, exceeding our goal of achieving a 5% minimum decrease from first quarter 2018 to first quarter 2019.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2019	**PACE Alternative Care Setting Sites** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Partnered with five Alternative Care Setting sites throughout Orange County, which now serve approximately 15% of CalOptima PACE participants.
✓ 2019	**PACE Letters of Support Process** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Administered a process to accept and assess requests for letters of support from PACE organizations seeking to operate independently in Orange County. Board approved issuing two letters of support
✓ 2019	**Coding Improvements** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* Workforce Performance *Operational Excellence* Financial Strength *Fiscal Management*	Engaged a vendor to transition the processing and analysis of Hierarchical Condition Category (HCC) and Risk Adjustment Factor (RAF) scores, with a goal of enhanced accuracy and increased reimbursement.
✓ 2019	**Directed Payments for Hospitals** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* Financial Strength *Fiscal Management*	Collaborated with the local hospital association and provider community to implement a new directed payments process, including holding educational events to ensure their understanding of the requirements to obtain the supplemental funding.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2019	**OneCare Connect Marketing and Retention** **Strategic Plan Elements:** Innovation *Program Integration* Workforce Performance *Operational Excellence*	Developed 2019–20 plan to increase OneCare Connect membership through new sales and marketing initiatives, including member events.
✓ 2018	**NCQA Recognition** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* *Member Engagement* *Community Partnerships* Workforce Performance *Operational Excellence*	Delivered quality health care and customer service, as assessed by the National Committee for Quality Assurance (NCQA), thereby maintaining CalOptima's top rating among California Medi-Cal plans for the fifth year in a row.
✓ 2018	**State Quality Award** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* *Member Engagement* *Community Partnerships* Workforce Performance *Operational Excellence*	Recognized by DHCS for quality, earning the Outstanding Performance Award for a Large Scale Medi-Cal Plan for the fourth year in a row.
✓ 2018	**NCQA Accreditation** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* Value *Cost-Effectiveness* Workforce Performance *Operational Excellence*	Achieved accreditation at the Commendable level after earning a near-perfect score on the accreditation renewal survey in August 2018.
✓ 2018	**Rate Rebasing** **Strategic Plan Elements:** Value *Cost-Effectiveness* Financial Strength *Fiscal Management*	Rebased capitated payment rates for CalOptima's delegated health networks to reflect recent costs and delivery model changes, resulting in an increase of approximately $14 million for health networks in 2019.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2018	**Medical Loss Ratio (MLR) Audit** **Strategic Plan Elements:** Partnerships and Engagement *Provider Collaboration* Financial Strength *Fiscal Management*	Completed the audit of contracted health networks' MLRs to ensure required rate of 85% or more in medical spending; requested corrective action plans from networks out of compliance.
✓ 2018	**PACE Service Area Expansion** **Strategic Plan Elements:** Innovation *Delivery System Innovation* Partnerships and Engagement *Provider Collaboration* *Community Partnerships*	Gained regulatory approval to serve all ZIP codes in Orange County, which enables CalOptima to reach seniors living in South Orange County.
✓ 2018	**Dual Eligible Special Needs Plan (D-SNP) Reauthorization** **Strategic Plan Element:** Partnerships and Engagement *Shared Advocacy*	Worked with members of Congress and in partnership with our associations to obtain permanent reauthorization of D-SNP plans, including CalOptima's OneCare.
✓ 2018	**Children's Health Insurance Program (CHIP) Reauthorization** **Strategic Plan Elements:** Partnerships and Engagement *Community Partnerships* *Shared Advocacy*	Worked with federal advocates and trade associations to gain a 10-year reauthorization of CHIP funding, through 2027.
✓ 2018	**Member Health Needs Assessment** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Community Partnerships* Innovation *Program Incubation*	Finalized the data and compiled a 70-page report summarizing five key findings in these areas: social determinants of health, mental health, primary care, provider access and dental care.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2018	**Regulatory Audits** **Strategic Plan Elements:** Value *Cost-Effectiveness* Workforce Performance *Operational Excellence*	Maintained a culture of compliance to ensure CalOptima and delegated entities were continuously audit-ready. DHCS and the Centers for Medicare & Medicaid Services conducted nine regulatory audits of CalOptima's programs in 2018. The annual Medi-Cal audit resulted in our best performance ever, with only one finding.
✓ 2018	**Child Health and Disability Prevention (CHDP)** **Strategic Plan Elements:** Innovation *Program Integration* Workforce Performance *Operational Excellence*	Improved the claims process for providers delivering CHDP services by transitioning responsibility for CHDP services from CalOptima to the health networks.
✓ 2018	**Medi-Cal Provider Enrollment** **Strategic Plan Element:** Partnerships and Engagement *Provider Collaboration*	Led efforts to ensure providers were enrolled in Medi-Cal by January 1, 2019, in compliance with new regulations. Through outreach, 139 primary care providers became enrolled or started the process, thereby eliminating the need for members to change providers.
✓ 2018	**Whole-Child Model (WCM) Provider Network** **Strategic Plan Element:** Partnerships and Engagement *Provider Collaboration*	Built a network of California Children's Services-paneled providers that complied with revised state requirements on network adequacy. Collaborated with health networks and contracted with independent providers to ensure the network was in place for a filing deadline of January 2, 2019.
✓ 2018	**WCM Family Advisory Committee** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Community Engagement*	Appointed the founding members of our newest advisory committee, which will guide our effective implementation of WCM.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2018	**Applied Behavior Analysis (ABA) for Non-Autism Diagnoses** **Strategic Plan Elements:** Innovation *Program Integration* Partnerships and Engagement *Member Engagement*	Prepared for another transition of behavioral health services, integrating ABA services for children with non-Autism Spectrum Disorders, effective July 1, 2018.
✓ 2018	**Childhood Obesity Program** **Strategic Plan Elements:** Innovation *Program Incubation* Value *Cost-Effectiveness* Partnerships and Engagement *Member Engagement*	Redesigned and implemented Shape Your Life, a comprehensive program to address childhood obesity.
✓ 2018	**Perinatal Care** **Strategic Plan Elements:** Innovation *Program Incubation* Value *Pay for Value* Partnerships and Engagement *Provider Collaboration* *Member Engagement*	Launched Bright Steps to provide quality prenatal and postpartum services to members through a program that reflects best practices and includes provider incentives.
✓ 2018	**Quality Care Campaign** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* Workforce Performance *Employer of Choice*	Created and implemented a multifaceted marketing campaign to raise awareness of preventive care at all ages, from infancy to the golden years.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2018	**Timekeeping Enhancements** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* *Operational Excellence*	Implemented a timekeeping system for all nonexempt employees using timeclocks to ensure staff accountability and efficiency across the agency.
✓ 2018	**457(b) Vendor Change** **Strategic Plan Element:** Workforce Performance *Employer of Choice*	Improved overall employee experience with CalOptima's 457(b) plan by changing to a vendor with enhanced plan administration, a simplified investment selection, and improved tools and education.
✓ 2018	**Crucial Conversations Course** **Strategic Plan Element:** Workforce Performance *Collaborative Culture*	Engaged leaders and staff in a high-priority, skill-based training class, conducted by a CalOptima facilitator who will offer the course on an ongoing basis.
✓ 2017	**Behavioral Health Integration** **Strategic Plan Elements:** Innovation *Delivery System Innovation* *Program Integration* Value *Cost-Effectiveness* Partnerships and Engagement *Provider Collaboration*	Quickly developed and capably implemented all the necessary infrastructure to manage the provision of Medi-Cal behavioral health services for mild to moderate conditions and ABA services using a network of CalOptima-contracted providers, with a go-live date of December 29, 2017.
✓ 2017	**Non-Medical Transportation** **Strategic Plan Element:** Innovation *Program Integration*	Implemented the benefit to provide non-medical transportation for adults traveling to Medi-Cal services covered by CalOptima and services carved out, thereby removing barriers to accessing all types of care.
✓ 2017	**Palliative Care** **Strategic Plan Elements:** Innovation *Program Integration* Value *Cost-Effectiveness*	Adopted appropriate policies and procedures to ensure the delivery of palliative care services through Medi-Cal, with the goal of providing access to cost-effective and compassionate care to members with chronic illnesses or members at the end of life.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2017	**OneCare Connect Program Reauthorization** **Strategic Plan Elements:** Innovation *Program Integration* Partnerships and Engagement *Shared Advocacy*	Successfully advocated for DHCS and the Legislature to reauthorize the Cal MediConnect program, including CalOptima's OneCare Connect program, through 2019. SB 97 passed the Legislature and was signed by the governor on July 10, 2017.
✓ 2017	**OneCare Connect Enrollment** **Strategic Plan Element:** Partnerships and Engagement *Member Engagement*	Changed enrollment policies in OneCare Connect to help minimize disruption of services to members while their eligibility status is being updated.
✓ 2017	**Nurse Practitioners at PACE** **Strategic Plan Element:** Innovation *Delivery System Innovation*	Successfully advocated for federal approval for CalOptima PACE nurse practitioners to perform routine primary care services, resulting in reduced costs while maintaining high-quality care.
✓ 2017	**Mega Reg Implementation: GARS** **Strategic Plan Element:** Innovation *Program Integration*	Completed a timely and effective implementation of the first stage of Mega Reg-related changes, specifically an updated Grievance and Appeals Resolution Services (GARS) process for Medi-Cal members. The Mega Reg modernized Medicaid managed care regulations to improve members' experience.
✓ 2017	**New Federal Advocate** **Strategic Plan Element:** Partnerships and Engagement *Shared Advocacy*	Transitioned to a new federal advocate, Akin Gump, a top-tier Washington, D.C.-based firm with extensive health care experience, ensuring important guidance remains available considering the changing landscape of federal health care reform.
✓ 2017	**FY 2017 Financial Audit** **Strategic Plan Element:** Financial Strength *Fiscal Management*	Completed CalOptima's annual financial audit, with positive results in that the auditor found no material misstatements and made no changes.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2017	**2017 Pay for Value Program** **Strategic Plan Element:** Value *Pay for Value*	Created a payment incentive to reward providers who show improvement in high-impact areas, such as preventive care and hospital readmission.
✓ 2017	**Member and Provider Incentives** **Strategic Plan Elements:** Partnerships and Engagement *Member Engagement* *Provider Collaboration*	Adopted new quality initiatives to improve members' health outcomes, specifically in postpartum care, cervical cancer screenings and breast cancer screenings.
✓ 2017	**Good Health Campaign** **Strategic Plan Element:** Partnerships and Engagement *Member Engagement*	Launched a major health education campaign in 2017 to promote preventive health screenings and better wellness practices. The campaign aimed to improve members' health behaviors and health outcomes.
✓ 2017	**Community Events Policies Update** **Strategic Plan Element:** Partnerships and Engagement *Community Partnerships*	Improved CalOptima's community events policies so community partners can more easily request support and staff can respond based on new Board-approved financial thresholds.
✓ 2017	**CCSC Location** **Strategic Plan Element:** Partnerships and Engagement *Community Partnerships*	Successfully extended CalOptima's agreement with the Orange County Social Services Agency to continue providing community resources and information at the County Community Service Center (CCSC).
✓ 2017	**Information Technology: CORE Standards** **Strategic Plan Element:** Value *Data Analytics Infrastructure*	Improved the speed and efficiency of claims processing by implementing Committee on Operating Rules for Information Exchange (CORE) Standards. Providers will now have quicker, more cost-effective access to member claims data.
✓ 2017	**Tableau Implementation** **Strategic Plan Elements:** Value *Data Analytics Infrastructure* *Pay for Value*	Procured a new business intelligence and data analytics platform to promote departmental self-service analytics and data-based decision making.

Back to Agenda

Completed Projects

CalOptima Strategic Plan 2017–2019

✓ 2017	**Information Security** **Strategic Plan Element:** Workforce Performance *Operational Excellence*	Improved the protection of members' sensitive personal and health information through our information technology security workforce, preventing critical threats to CalOptima's systems.
✓ 2017	**Workforce Development** **Strategic Plan Elements:** Workforce Performance *Employer of Choice* *Collaborative Culture*	Offered a complete array of employee engagement opportunities, including quarterly All Hands meetings, health and wellness events, Employee Activities Committee activities, member scholarship contest, and performance reviews/feedback. Launched the new Leadership Development Series to improve leaders' skills via education provided by outside experts.

Back to Agenda

STRATEGIC PLAN 2020–2022

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Back to Agenda

A Message From the CEO

Like many of you, I consider the beginning of the new 2020 decade as an opportunity to look ahead and to plan. So, it is the perfect time to launch CalOptima's next Strategic Plan, for 2020–2022. The guidance it offers and the priorities it sets have been carefully considered by a wide variety of leaders, including our Board of Directors, advisory committee members, executive staff, community stakeholders and industry consultants. Collaboration strengthens our plan and reflects our Better. Together. approach to quality health care for Orange County's vulnerable low-income residents.

If this decade is anything like the last, the one constant will be change. Recognition of this fact is central to the content of CalOptima's Strategic Plan. An overview of the health care landscape explains the federal, state and local drivers of change, followed by our strategic priorities and objectives in this environment.

Responding effectively in dynamic conditions does not mean CalOptima will alter our mission or vision, both of which are focused on members. Our commitment to members is as strong as ever, and you will see that dedication underlying all the priority areas, from innovation and community partnerships to value, quality and operational excellence. While we may adjust our efforts along the way in response to regulatory changes or community needs, we will not waver about putting members first.

And one final comment about 2020 — it's CalOptima's 25th anniversary year. We celebrate you and all the providers, community-based organizations, elected officials and stakeholders who partner with us. Together, we have accomplished so much, including statewide recognition year after year as a leading Medi-Cal health plan. Our shared goal of a healthier Orange County has brought us far and will carry us confidently into the future.

Michael Schrader
Chief Executive Officer

Back to Agenda

About CalOptima

CalOptima's Mission

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

CalOptima's 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 our members

Programs

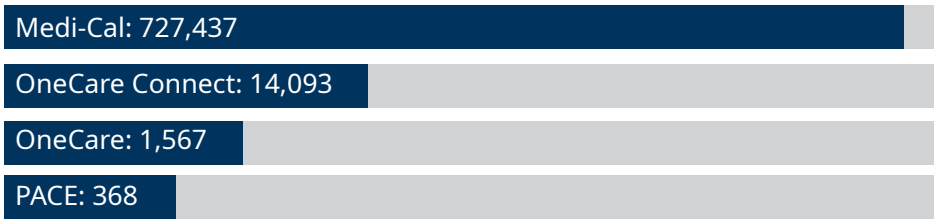
Medi-Cal (California's Medicaid Program): For low-income children, adults, seniors and persons with disabilities.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan): For people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits. Also included are benefits for worldwide emergency care, dental care, vision care and fitness. Other benefits are transportation to medical services and a Personal Care Coordinator.

OneCare (HMO SNP): A Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. Benefits are covered in one single plan, making it easier to get health care.

Program of All-Inclusive Care for the Elderly (PACE): A long-term comprehensive health care program that helps older adults remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community. PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal.

As of October 31, 2019, CalOptima has approximately 743,000 members:



Health Insurance Coverage in Orange County

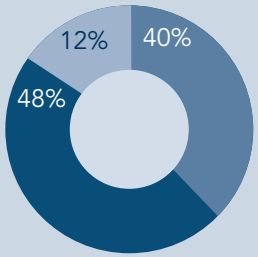
CalOptima covers more than 20% of Orange County residents.

Current Health Insurance Coverage Type	Orange County
Uninsured	6.7%
Medicare and Medicaid (Dual Eligibles)	3.0%
Medicare	11.2%
Medicaid	19.1%
Employment-Based	51.8%
Privately Purchased	7.5%
Other Public Coverage	0.7%

Source: California Health Interview Survey, 2017

CalOptima Profile

Members by Age



Age 0–18	40%
Age 19–64	48%
Age 65+	12%

As of October 31, 2019

Low Administrative Costs

CalOptima spends nearly 96 cents of every dollar on member care and only 4 cents on program administration, which reinforces our commitment and mission as a community health plan that provides quality health care services in a cost-effective, compassionate manner.

96¢ of every **$1**

Provider Network Composition

CalOptima has a strong provider network to serve our members. As of October 31, 2019, this includes:

- 1,567 primary care providers
- 6,944 specialists
- 40 acute and rehab hospitals
- 35 community health centers
- 570 pharmacies
- 100 long-term care facilities
- 5 PACE alternative care settings

High-Quality Care

CalOptima offers high-quality care to our members:

- For five years in a row, CalOptima was the top rated Medi-Cal plan in California, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings (2014–2019).
- For 2019–2020, no other health plan received a higher rating.
- NCQA has awarded an accreditation status of Commendable to CalOptima Medi-Cal.

Back to Agenda

Health Care Landscape Review

CalOptima's 2020–2022 Strategic Plan reflects the need to be responsive to a wide variety of federal, state and local priorities, considerations and issues. The landscape review is a summary of highlights from a comprehensive Environmental Scan that was completed to inform the Strategic Plan.

Federal Landscape

At the federal level, the policy landscape has been characterized by uncertainty for the past three years, and this is expected to continue for the foreseeable future. The Centers for Medicare & Medicaid Services (CMS), which provides the federal funding for, and oversight of, California's Medi-Cal program, has established a set of strategic priorities focused on driving innovation, implementing patient-centric approaches, and demonstrating results that improve care and lower costs. CalOptima will look to CMS's goals to prioritize development of innovative approaches that are aligned with the federal government. In addition, federal immigration policy may negatively impact Medi-Cal enrollment.

State Landscape

Within California, the health policy landscape is in transition with the election of Governor Gavin Newsom. Governor Newsom has an ambitious health care agenda focused on expanding coverage for all Californians and reigning in costs. Within the California Department of Health Care Services (DHCS), key initiatives are underway that will shape the future of the Medi-Cal program and impact CalOptima's work over the next three years.

Medi-Cal Vision: 2021 and Beyond

The current federal Section 1115 Medicaid waiver, referred to as Medi-Cal 2020, expires at the end of 2020. As part of renewing the waiver, DHCS has launched a major restructuring of Medi-Cal, known as California Advancing and Innovating Medi-Cal (CalAIM), which is designed to reduce the complexity of the program, focus on population health and increase the use of value-based purchasing strategies. CalOptima will contribute to the CalAIM discussions and, ultimately, to the implementation of Medi-Cal's next chapter.

Prescription Drug Carve-Out

On his first day in office, Governor Newsom signaled his intent to address rising pharmacy costs by shifting to bulk purchasing of prescription drugs for all government programs, including Medi-Cal (the largest purchaser in the state). CalOptima will continue to work closely with DHCS on the design of the carve-out to minimize the impacts on our members and their health.

Future of the Coordinated Care Initiative and Cal MediConnect

The Coordinated Care Initiative (CCI) focuses on integrating delivery of medical, behavioral and long-term services and supports (MLTSS) benefit into California's Medi-Cal care delivery system. The CCI also includes the Cal MediConnect (CMC) duals demonstration, combing Medicare and Medi-Cal into a single program. CCI and CMC are currently operating in only seven counties and the federal authority for CMC is scheduled to sunset on December 31, 2022. As part of the CalAIM initiative, DHCS has proposed that all Medi-Cal managed care plans, including CalOptima, be required to operate a Dual Eligible Special Needs Plan (D-SNP) by January 1, 2023, and assume responsibility for all Medi-Cal long-term care services effective January 1, 2021. CalOptima will engage with DHCS and CMS on the CCI and CMC transitions.

Back to Agenda

Health Care Landscape Review (continued)

Orange County Landscape

CalOptima is an integral part of the business community and the health care sector in Orange County. As the sole Medi-Cal plan in the County, CalOptima is in a unique position to impact care delivery and partner with County agencies and other stakeholders to improve access to care and quality for all members.

Homelessness and Behavioral Health

In Orange County, as across the state, the population of individuals experiencing homelessness has increased significantly over the past few years. Orange County has focused on developing a system of care that recognizes a multifaceted approach is necessary to respond to the needs of County residents experiencing homelessness. CalOptima has committed enhanced funding for homeless health programs in the County. For example, CalOptima is funding programs in collaboration with its community health centers to provide members on-call medical services in the field and increased preventive and primary care at shelters, establishing an internal homeless response team, and supporting hospital discharge coordination, recuperative care and respite care.

In 2018, local public and private stakeholders came together to work on behavioral health issues. Under this initiative, known as Be Well OC, a regional wellness center will be constructed in Orange County to serve individuals with mental health needs regardless of payor source. CalOptima is participating in this collaborative by prepaying for services at the Be Well OC wellness center. Be Well OC is part of the larger Mind OC initiative to integrate behavioral health services across silos to address social determinants of health.

CalOptima Workforce Needs

CalOptima will continue to face an extremely competitive employment environment over the next three years. The high cost of living in Orange County coupled with the County's low unemployment rate, staff retirements and turn-over contribute to a tight labor market.

Physician Networks and Access to Care

Across California, there are concerns about access to care, the rising cost of living, and a lack of physicians and other health workers. These issues are particularly acute in the Medi-Cal program. To address access issues, CalOptima will continue to develop stronger networks with innovative value-based payment arrangements over the next three years.

Back to Agenda

Strategic Plan Development Process

To develop our 2020–2022 Strategic Plan, we gathered input from a wide range of CalOptima stakeholders:

Step 1

CalOptima's Board members, executive team and advisory committee leaders were interviewed to gather feedback about the 2017–2019 Strategic Plan as well as the issues and challenges facing the health plan over the next three years.

Step 2

Then, we held a Strategic Planning Session with the Board to review the findings from the interviews and to identify and discuss the priorities for the next Strategic Plan given the health care landscape in which CalOptima operates.

Step 3

Following the Strategic Planning Session, we held a joint meeting of all the advisory committees to solicit their input on the strategic priorities. We also convened health network representatives to gather their input on the next Strategic Plan.

Step 4

The draft 2020–2022 Strategic Plan was presented to the Board on November 7, 2019, for review and discussion.

Step 5

The final 2020–2022 Strategic Plan was adopted by the Board on December 5, 2019.

Back to Agenda

Strategic Priorities and Objectives

Our members are the essential focus of the Strategic Priorities and Objectives for the 2020–2022 Strategic Plan and are supported by the programs and services provided by CalOptima.

Innovate and Be Proactive

- Anticipate Likely CMS and DHCS Priorities
- Identify and Collaborate on Local Priorities and Needs
- Leverage New Federal and State Programs and Services to Improve Access and Quality of Care for Members
- Seek Opportunities to Further Integrate Care for Members

Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Strengthen Community Partnerships

- Increase Collaboration with Providers and Community Stakeholders to Improve Care
- Utilize Strong Advisory Committee Participation to Inform Additional Community Engagement Strategies

Increase Value and Improve Care Delivery

- Evaluate and Implement Value-Based Purchasing Strategies that Drive Quality
- Deploy Innovative Delivery Models to Address Social Determinants of Health and Homelessness
- Maintain Focus on Providing High-Quality Care to Members

Enhance Operational Excellence and Efficiency

- Maintain Strong Culture of Compliance
- Preserve CalOptima's Financial Stability
- Invest in Infrastructure and Efficient Processes
- Engage Workforce and Identify Development Opportunities

Back to Agenda

Board of Directors

Paul Yost, M.D. (Chair)
Anesthesiologist, CHOC Children's and St. Joseph Hospital
Designed seat: Licensed physician, representing a health network

Dr. Nikan Khatibi (Vice Chair)
Anesthesiologist, Pain Specialist and Addiction Medicine Physician
Designated seat: Licensed medical professional, not representing a health network

Ria Berger
CEO, Healthy Smiles for Kids of Orange County
Designated seat: Community clinic representative

Doug Chaffee
Orange County Board of Supervisors Supervisor, Fourth District
Designated seat: Orange County Board of Supervisors (alternate)

Ron DiLuigi
Retired Health Care Executive
Designated seat: Legal resident of Orange County

Andrew Do
Orange County Board of Supervisors Supervisor, First District
Designated seat: Orange County Board of Supervisors

Alexander Nguyen, M.D., MPH
Psychiatrist, Long Beach Veterans Affairs Medical Center
Designated seat: Family member of a CalOptima member

Lee Penrose
Health Care Executive
Designated seat: Current or former hospital administrator

Richard Sanchez, REHS, MPH
Director, Orange County Health Care Agency
Designated seat (non-voting): Orange County Health Care Agency

J. Scott Schoeffel
Attorney
Designated seat: Legal or finance professional

Michelle Steel
Orange County Board of Supervisors Supervisor, Second District
Designated seat: Orange County Board of Supervisors

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www.caloptima.org

The 2020–2022 Strategic Plan was created with the assistance of Athena Chapman and Caroline Davis from Champan Consulting. This plan was adopted by the CalOptima Board of Directors on December 5, 2019, and provides a framework for future direction. This document does not authorize expenditure of funds or commitment of resources.

Back to Agenda

A Public Agency

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Chief Executive Officer Recruitment Update

Board of Directors Meeting
September 3, 2020

Brigette Gibb, Executive Director of Human Resources

Back to Agenda

Board Actions related to Chief Executive Officer Vacancy

- March 2020 – Former Chief Executive Officer (CEO) resigned effective May 3, 2020
- March 2020 – Board directed staff to support Chair and Vice-Chair in negotiating executive employment agreement with Richard Sanchez as Interim CEO
- April 2020 – Board approved employment agreement with Interim CEO Richard Sanchez effective April 6, 2020
- May 2020 – Board authorized contract with Witt Kieffer for executive search services for the CEO position

Back to Agenda

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Current Status

- June/July 2020 – Contract discussions with Witt Kieffer
- August 2020 – Contract with Witt Kieffer finalized and executed (August 5, 2020)
- August 2020 – New Board members are seated
- September 2020 – Election of Chair and Vice-Chair included on September Board agenda

Back to Agenda

CalOptima
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Next Step

- Staff is requesting that the Chair consider establishing an executive search ad hoc committee to provide direction to Witt Kieffer and Human Resources, and to keep the other Board members apprised relative to the CEO recruitment process.

Back to Agenda

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Our Mission

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

Back to Agenda

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Financial Summary

July 31, 2020

Board of Directors Meeting

September 3, 2020

Nancy Huang, Chief Financial Officer

Back to Agenda

FY 2020-21: Consolidated Enrollment

July 2020 MTD

Overall enrollment was 767,745 members

- Actual lower than budget 2,767 or 0.4%
  - Medi-Cal unfavorable to budget 3,226 or 0.4%
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 5,053
    - Whole-Child Model (WCM) unfavorable variance of 2,858
    - Long-Term Care (LTC) unfavorable variance of 75
    - Medi-Cal Expansion (MCE) favorable variance of 3,130
    - Seniors and Persons With Disabilities (SPD) favorable variance of 1,613
    - Breast and Cervical Cancer Treatment Program (BCCTP) favorable variance of 17

Back to Agenda

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FY 2020-21: Consolidated Enrollment (cont.)

July 2020 MTD

- OneCare Connect favorable to budget 331 or 2.3%
- OneCare favorable to budget 147 or 10.7%
- PACE unfavorable to budget 19 or 4.7%

- 8,775 increase or 1.2% from June
  - Medi-Cal increase of 8,604
  - OneCare Connect increase of 107
  - OneCare increase of 73
  - PACE decrease of 9

Back to Agenda

CalOptima
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FY 2020-21: Consolidated Revenues

July 2020 MTD

- Actual lower than budget $8.2 million or 2.6%
  - Medi-Cal unfavorable to budget $7.0 million or 2.5%
    - Unfavorable volume related variance of $1.2 million
    - Unfavorable price related variance of $5.8 million due to revenue from WCM
  - OneCare Connect unfavorable to budget $1.4 million or 5.3%
    - Favorable volume related variance of $0.6 million
    - Unfavorable price related variance of $2.0 million due to Coordinated Care Initiative (CCI) cohort mix and Part D payment reconciliation

Back to Agenda

CalOptima
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FY 2020-21: Consolidated Revenues (cont.)

July 2020 MTD

- OneCare favorable to budget $0.4 million or 21.2%
  - Favorable volume related variance of $0.2 million
  - Favorable price related variance of $0.2 million
- PACE unfavorable to budget $0.1 million or 2.6%
  - Unfavorable volume related variance of $0.2 million
  - Favorable price related variance of $0.1 million

Back to Agenda

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FY 2020-21: Consolidated Medical Expenses

July 2020 MTD

- Actual lower than budget $6.5 million or 2.1%
  - Medi-Cal favorable variance of $8.1 million or 2.9%
    - Favorable volume related variance of $1.2 million
    - Favorable price related variance of $6.9 million primarily due to decrease in utilization during COVID-19 pandemic
      - Provider Capitation expense favorable variance of $3.9 million due to Proposition 56
      - Facilities Claims expense favorable variance of $3.1 million
      - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $1.2 million
      - Professional Claims expense favorable variance of $1.1 million
      - Offset by Prescription Drugs expense unfavorable variance of $2.9 million due to increased utilization

Back to Agenda

CalOptima
A Public Agency

FY 2020-21: Consolidated Medical Expenses (cont.)

July 2020 MTD

- OneCare Connect unfavorable variance of $2.1 million or 8.1%
  - Unfavorable volume related variance of $0.6 million
  - Unfavorable price related variance of $1.5 million
- OneCare unfavorable variance of $140,749 or 9.3 %
  - Unfavorable volume related variance of $160,902
  - Favorable price related variance of $20,153
- PACE favorable variance of $0.6 million or 18.7%
  - Favorable volume related variance of $0.1 million
  - Favorable price related variance of $0.4 million

Medical Loss Ratio

July 2020 MTD Actual: 97.7% Budget: 97.2%

Back to Agenda

CalOptima A Public Agency

FY 2020-21: Consolidated Administrative Expenses

July 2020 MTD

- Actual lower than budget $1.3 million or 10.1%
  - Salaries, wages and benefits: favorable variance of $0.1 million
  - Other categories: favorable variance of $1.2 million

Administrative Loss Ratio

July 2020 MTD Actual: 3.8% Budget: 4.1%

Back to Agenda

CalOptima A Public Agency

FY 2020-21: Change in Net Assets

July 2020 MTD

- ($3.1) million change in net assets
- $0.2 million unfavorable to budget
  - Lower than budgeted revenue of $8.2 million
  - Lower than budgeted medical expenses of $6.5 million
  - Lower than budgeted administrative expenses of $1.3 million
  - Higher than budgeted investment and other income of $0.1 million

Back to Agenda

CalOptima
A Public Agency

Enrollment Summary: July 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
112,390	110,777	1,613	1.5%	SPD	112,390	110,777	1,613	1.5%
510	493	17	3.4%	BCCTP	510	493	17	3.4%
288,238	297,353	(9,115)	(3.1%)	TANF Child	288,238	297,353	(9,115)	(3.1%)
93,572	89,510	4,062	4.5%	TANF Adult	93,572	89,510	4,062	4.5%
3,430	3,505	(75)	(2.1%)	LTC	3,430	3,505	(75)	(2.1%)
244,159	241,029	3,130	1.3%	MCE	244,159	241,029	3,130	1.3%
9,074	11,932	(2,858)	(24.0%)	WCM	9,074	11,932	(2,858)	(24.0%)
751,373	**754,599**	**(3,226)**	**(0.4%)**	**Medi-Cal Total**	**751,373**	**754,599**	**(3,226)**	**(0.4%)**
14,465	**14,134**	**331**	**2.3%**	**OneCare Connect**	**14,465**	**14,134**	**331**	**2.3%**
1,525	**1,378**	**147**	**10.7%**	**OneCare**	**1,525**	**1,378**	**147**	**10.7%**
382	**401**	**(19)**	**(4.7%)**	**PACE**	**382**	**401**	**(19)**	**(4.7%)**
767,745	**770,512**	**(2,767)**	**(0.4%)**	**CalOptima Total**	**767,745**	**770,512**	**(2,767)**	**(0.4%)**

Back to Agenda

CalOptima
A Public Agency

Financial Highlights: July 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
767,745	770,512	(2,767)	(0.4%)	Member Months	767,745	770,512	(2,767)	(0.4%)
308,706,210	316,857,646	(8,151,436)	(2.6%)	Revenues	308,706,210	316,857,646	(8,151,436)	(2.6%)
301,473,585	307,960,102	6,486,517	2.1%	Medical Expenses	301,473,585	307,960,102	6,486,517	2.1%
11,767,983	13,084,203	1,316,220	10.1%	Administrative Expenses	11,767,983	13,084,203	1,316,220	10.1%
(4,535,357)	**(4,186,659)**	**(348,698)**	**(8.3%)**	**Operating Margin**	**(4,535,357)**	**(4,186,659)**	**(348,698)**	**(8.3%)**
1,386,587	1,250,000	136,587	10.9%	Non Operating Income (Loss)	1,386,587	1,250,000	136,587	10.9%
(3,148,770)	**(2,936,659)**	**(212,111)**	**(7.2%)**	**Change in Net Assets**	**(3,148,770)**	**(2,936,659)**	**(212,111)**	**(7.2%)**
97.7%	97.2%	(0.5%)		Medical Loss Ratio	97.7%	97.2%	(0.5%)	
3.8%	4.1%	0.3%		Administrative Loss Ratio	3.8%	4.1%	0.3%	
(1.5%)	(1.3%)	(0.1%)		Operating Margin Ratio	(1.5%)	(1.3%)	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
A Public Agency

Consolidated Performance Actual vs. Budget: July 2020 (in millions)

	MONTH-TO-DATE		
	Actual	Budget	Variance
Medi-Cal	(1.0)	(3.3)	2.3
OCC	(4.4)	(1.1)	(3.3)
OneCare	0.2	0.0	0.2
PACE	0.6	0.1	0.5
Operating	**(4.5)**	**(4.2)**	**(0.3)**
Inv./Rental Inc, MCO tax	1.4	1.3	0.1
Non-Operating	**1.4**	**1.3**	**0.1**
TOTAL	**(3.1)**	**(2.9)**	**(0.2)**

Back to Agenda

CalOptima
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Consolidated Revenue & Expenses: July 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	498,140	244,159	9,074	751,373	14,465	1,525	382	767,745
REVENUES								
Capitation Revenue	147,685,707	$ 113,197,214	$ 17,950,465	$ 278,833,386	$ 24,646,229	$ 2,051,576	$ 3,175,020	$ 308,706,210
Total Operating Revenue	147,685,707	113,197,214	17,950,465	278,833,386	24,646,229	2,051,576	3,175,020	308,706,210
MEDICAL EXPENSES								
Provider Capitation	37,659,860	41,694,348	11,079,395	90,433,603	11,272,044	556,918		102,262,565
Facilities	25,401,569	24,453,376	4,088,740	53,943,685	4,970,703	428,483	645,971	59,988,842
Professional Claims	20,212,494	9,755,941	1,351,304	31,319,739	1,067,892	95,750	521,466	33,004,847
Prescription Drugs	21,459,900	25,071,494	2,325,458	48,856,852	6,855,415	480,805	271,574	56,464,647
MLTSS	34,881,885	2,819,047	1,445,936	39,146,868	1,846,604	51,695	(2,845)	41,042,322
Medical Management	2,608,133	1,463,337	309,334	4,380,804	1,165,545	35,421	836,720	6,418,490
Quality Incentives	777,464	454,673	31,542	1,263,679	212,415		4,775	1,480,869
Reinsurance & Other	353,965	183,358	11,011	548,333	136,212		126,458	811,003
Total Medical Expenses	143,355,270	105,895,573	20,642,720	269,893,563	27,526,830	1,649,072	2,404,119	301,473,585
Medical Loss Ratio	97.1%	93.5%	115.0%	96.8%	111.7%	80.4%	75.7%	97.7%
GROSS MARGIN	**4,330,437**	**7,301,640**	**(2,692,254)**	**8,939,822**	**(2,880,601)**	**402,503**	**770,901**	**7,232,626**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,226,965	753,773	102,284	134,473	8,217,495
Professional fees				290,786	5,333	16,000	40	312,159
Purchased services				721,866	93,431	827	2,603	818,727
Printing & Postage				248,656	63,615	6,153	4,262	322,685
Depreciation & Amortization				294,845			2,089	296,934
Other expenses				1,392,334	42,544		1,405	1,436,283
Indirect cost allocation & Occupancy				(229,074)	553,492	35,185	4,097	363,700
Total Administrative Expenses				9,946,377	1,512,188	160,448	148,970	11,767,983
Admin Loss Ratio				3.6%	6.1%	7.8%	4.7%	3.8%
INCOME (LOSS) FROM OPERATIONS				(1,006,555)	(4,392,788)	242,055	621,931	(4,535,357)
INVESTMENT INCOME								2,150,661
TOTAL MCO TAX				(769,436)				(769,436)
TOTAL GRANT INCOME				5,288				5,288
OTHER INCOME				75				75
CHANGE IN NET ASSETS				**$ (1,770,629)**	**$ (4,392,788)**	**$ 242,055**	**$ 621,931**	**$ (3,148,770)**
BUDGETED CHANGE IN NET ASSETS				(3,289,595)	(1,088,863)	44,208	147,591	(2,936,659)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,518,966	$ (3,303,925)	$ 197,847	$ 474,340	$ (212,111)

Back to Agenda

CalOptima
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Balance Sheet: as of July 31, 2020

ASSETS		
Current Assets		
Operating Cash		$458,374,737
Investments		690,461,039
Capitation receivable		325,603,665
Receivables - Other		44,422,192
Prepaid expenses		7,166,364
Total Current Assets		**1,526,027,996**
Capital Assets		
Furniture & Equipment	39,890,502	
Building/Leasehold Improvements	9,779,070	
505 City Parkway West	51,620,226	
	101,289,798	
Less: accumulated depreciation	(53,811,879)	
Capital assets, net		47,477,919
Other Assets		
Restricted Deposit & Other		300,000
Homeless Health Reserve		57,198,913
Board-designated assets:		
Cash and Cash Equivalents	3,775,421	
Long-term Investments	582,703,374	
Total Board-designated Assets		586,478,794
Total Other Assets		643,977,707
TOTAL ASSETS		**2,217,483,622**
Deferred Outflows		
Contributions		1,047,297
Difference in Experience		4,280,308
Excess Earning		-
Changes in Assumptions		5,060,465
OPEB 75 Changes in Assumptions		703,000
Pension Contributions		570,000
TOTAL ASSETS & DEFERRED OUTFLOWS		**2,229,144,692**

LIABILITIES & NET POSITION		
Current Liabilities		
Accounts Payable		$86,044,382
Medical Claims liability		856,938,052
Accrued Payroll Liabilities		15,499,386
Deferred Revenue		47,248,663
Deferred Lease Obligations		160,858
Capitation and Withholds		141,513,332
Total Current Liabilities		**1,147,404,672**
Other (than pensions) post employment benefits liability		25,860,096
Net Pension Liabilities		27,220,125
Bldg 505 Development Rights		-
TOTAL LIABILITIES		**1,200,484,893**
Deferred Inflows		
Excess Earnings		506,547
OPEB 75 Difference in Experience		804,000
Change in Assumptions		3,728,725
OPEB Changes in Assumptions		1,638,000
Net Position		
TNE		101,080,707
Funds in Excess of TNE		920,901,820
TOTAL NET POSITION		1,021,982,527
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION		**2,229,144,692**

Back to Agenda

CalOptima
A Public Agency

Board Designated Reserve and TNE Analysis: as of July 31, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,471,248				
	Tier 1 - MetLife	159,222,998				
	Tier 1 - Wells Capital	159,645,487				
Board-designated Reserve		479,339,733	318,017,181	497,630,561	161,322,552	(18,290,829)
TNE Requirement	Tier 2 - MetLife	107,139,062	101,080,707	101,080,707	6,058,354	6,058,354
	Consolidated:	**586,478,794**	**419,097,888**	**598,711,268**	**167,380,906**	**(12,232,474)**
	Current reserve level	*1.96*	*1.40*	*2.00*		

Back to Agenda

CalOptima
A Public Agency

Our Mission

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

Back to Agenda

CalOptima
A Public Agency

UNAUDITED FINANCIAL STATEMENTS

July 31, 2020

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the One Month Ended July 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
767,745	770,512	(2,767)	(0.4%)	Member Months	767,745	770,512	(2,767)	(0.4%)
308,706,210	316,857,646	(8,151,436)	(2.6%)	Revenues	308,706,210	316,857,646	(8,151,436)	(2.6%)
301,473,585	307,960,102	6,486,517	2.1%	Medical Expenses	301,473,585	307,960,102	6,486,517	2.1%
11,767,983	13,084,203	1,316,220	10.1%	Administrative Expenses	11,767,983	13,084,203	1,316,220	10.1%
(4,535,357)	**(4,186,659)**	**(348,698)**	**(8.3%)**	**Operating Margin**	**(4,535,357)**	**(4,186,659)**	**(348,698)**	**(8.3%)**
1,386,587	1,250,000	136,587	10.9%	Non Operating Income (Loss)	1,386,587	1,250,000	136,587	10.9%
(3,148,770)	**(2,936,659)**	**(212,111)**	**(7.2%)**	**Change in Net Assets**	**(3,148,770)**	**(2,936,659)**	**(212,111)**	**(7.2%)**
97.7%	97.2%	(0.5%)		Medical Loss Ratio	97.7%	97.2%	(0.5%)	
3.8%	4.1%	0.3%		Administrative Loss Ratio	3.8%	4.1%	0.3%	
(1.5%)	(1.3%)	(0.1%)		Operating Margin Ratio	(1.5%)	(1.3%)	(0.1%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

CalOptima
Financial Dashboard
For the One Month Ended July 31, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	751,373	754,599	(3,226)	(0.4%)
OneCare Connect	14,465	14,134	331	2.3%
OneCare	1,525	1,378	147	10.7%
PACE	382	401	(19)	(4.7%)
Total	767,745	770,512	(2,767)	(0.4%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (1,771)	$ (3,290)	$ 1,519	46.2%
OneCare Connect	(4,393)	(1,089)	(3,304)	(303.4%)
OneCare	242	44	198	450.0%
PACE	622	148	474	320.3%
505 Bldg.	-	-	-	0.0%
Investment Income	2,151	1,250	901	72.1%
Total	$ (3,149)	$ (2,937)	$ (212)	(7.2%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.8%	97.3%	0.5
OneCare Connect	111.7%	97.8%	(13.8)
OneCare	80.4%	89.1%	8.8

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,946	$ 11,137	$ 1,190	10.7%
OneCare Connect	1,512	1,650	138	8.3%
OneCare	160	140	(21)	(14.9%)
PACE	149	158	9	5.8%
Total	$ 11,768	$ 13,084	$ 1,316	10.1%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,097	1,161	64
OneCare Connect	195	210	15
OneCare	10	9	(0)
PACE	88	116	28
Total	1,389	1,496	107

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	685	650	35
OneCare Connect	74	67	7
OneCare	156	148	8
PACE	4	3	1
Total	920	869	51

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	751,373	754,599	(3,226)	(0.4%)
OneCare Connect	14,465	14,134	331	2.3%
OneCare	1,525	1,378	147	10.7%
PACE	382	401	(19)	(4.7%)
Total	767,745	770,512	(2,767)	(0.4%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (1,771)	$ (3,290)	$ 1,519	46.2%
OneCare Connect	(4,393)	(1,089)	(3,304)	(303.4%)
OneCare	242	44	198	450.0%
PACE	622	148	474	320.3%
505 Bldg.	-	-	-	0.0%
Investment Income	2,151	1,250	901	72.1%
Total	$ (3,149)	$ (2,937)	$ (212)	(7.2%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.8%	97.3%	0.5
OneCare Connect	111.7%	97.8%	(13.8)
OneCare	80.4%	89.1%	8.8

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,946	$ 11,137	$ 1,190	10.7%
OneCare Connect	1,512	1,650	138	8.3%
OneCare	160	140	(21)	(14.9%)
PACE	149	158	9	5.8%
Total	$ 11,768	$ 13,084	$ 1,316	10.1%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,097	1,161	64
OneCare Connect	195	210	15
OneCare	10	9	(0)
PACE	88	116	28
Total	1,389	1,496	107

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	685	650	35
OneCare Connect	74	67	7
OneCare	156	148	8
PACE	4	3	1
Total	920	869	51

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended July 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	767,745		770,512		(2,767)	
REVENUE						
Medi-Cal	$ 278,833,386	$ 371.10	$ 285,872,280	$ 378.84	$ (7,038,894)	$ (7.74)
OneCare Connect	24,646,229	1,703.85	26,031,993	1,841.80	(1,385,764)	(137.95)
OneCare	2,051,576	1,345.30	1,692,116	1,227.95	359,460	117.35
PACE	3,175,020	8,311.57	3,261,257	8,132.81	(86,237)	178.76
Total Operating Revenue	308,706,210	402.09	316,857,646	411.23	(8,151,436)	(9.14)
MEDICAL EXPENSES						
Medi-Cal	269,893,563	359.20	278,025,123	368.44	8,131,560	9.24
OneCare Connect	27,526,830	1,903.00	25,471,121	1,802.12	(2,055,709)	(100.88)
OneCare	1,649,072	1,081.36	1,508,323	1,094.57	(140,749)	13.21
PACE	2,404,119	6,293.51	2,955,535	7,370.41	551,416	1,076.90
Total Medical Expenses	301,473,585	392.67	307,960,102	399.68	6,486,517	7.01
GROSS MARGIN	7,232,626	9.42	8,897,544	11.55	(1,664,918)	(2.13)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	8,217,495	10.70	8,324,497	10.80	107,002	0.10
Professional fees	312,159	0.41	369,346	0.48	57,187	0.07
Purchased services	818,727	1.07	1,277,205	1.66	458,478	0.59
Printing & Postage	322,685	0.42	569,735	0.74	247,050	0.32
Depreciation & Amortization	296,934	0.39	460,570	0.60	163,636	0.21
Other expenses	1,436,283	1.87	1,696,661	2.20	260,378	0.33
Indirect cost allocation & Occupancy expense	363,700	0.47	386,189	0.50	22,489	0.03
Total Administrative Expenses	11,767,983	15.33	13,084,203	16.98	1,316,220	1.65
INCOME (LOSS) FROM OPERATIONS	(4,535,357)	(5.91)	(4,186,659)	(5.43)	(348,698)	(0.48)
INVESTMENT INCOME						
Interest income	1,329,516	1.73	1,250,000	1.62	79,516	0.11
Realized gain/(loss) on investments	1,246,869	1.62	-	-	1,246,869	1.62
Unrealized gain/(loss) on investments	(425,724)	(0.55)	-	-	(425,724)	(0.55)
Total Investment Income	2,150,661	2.80	1,250,000	1.62	900,661	1.18
TOTAL MCO TAX	(769,436)	(1.00)	-	-	(769,436)	(1.00)
TOTAL GRANT INCOME	5,288	0.01	-	-	5,288	0.01
OTHER INCOME	75	-	-	-	75	-
CHANGE IN NET ASSETS	**(3,148,770)**	**(4.10)**	**(2,936,659)**	**(3.81)**	**(212,111)**	**(0.29)**
MEDICAL LOSS RATIO	**97.7%**		**97.2%**		**-0.5%**	
ADMINISTRATIVE LOSS RATIO	**3.8%**		**4.1%**		**0.3%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended July 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	498,140	244,159	9,074	751,373	14,465	1,525	382	767,745
REVENUES								
Capitation Revenue	147,685,707	$ 113,197,214	$ 17,950,465	$ 278,833,386	$ 24,646,229	$ 2,051,576	$ 3,175,020	$ 308,706,210
Total Operating Revenue	147,685,707	113,197,214	17,950,465	278,833,386	24,646,229	2,051,576	3,175,020	308,706,210
MEDICAL EXPENSES								
Provider Capitation	37,659,860	41,694,348	11,079,395	90,433,603	11,272,044	556,918		102,262,565
Facilities	25,401,569	24,453,376	4,088,740	53,943,685	4,970,703	428,483	645,971	59,988,842
Professional Claims	20,212,494	9,755,941	1,351,304	31,319,739	1,067,892	95,750	521,466	33,004,847
Prescription Drugs	21,459,900	25,071,494	2,325,458	48,856,852	6,855,415	480,805	271,574	56,464,647
MLTSS	34,881,885	2,819,047	1,445,936	39,146,868	1,846,604	51,695	(2,845)	41,042,322
Medical Management	2,608,133	1,463,337	309,334	4,380,804	1,165,545	35,421	836,720	6,418,490
Quality Incentives	777,464	454,673	31,542	1,263,679	212,415		4,775	1,480,869
Reinsurance & Other	353,965	183,358	11,011	548,333	136,212		126,458	811,003
Total Medical Expenses	143,355,270	105,895,573	20,642,720	269,893,563	27,526,830	1,649,072	2,404,119	301,473,585
Medical Loss Ratio	97.1%	93.5%	115.0%	96.8%	111.7%	80.4%	75.7%	97.7%
GROSS MARGIN	**4,330,437**	**7,301,640**	**(2,692,254)**	**8,939,822**	**(2,880,601)**	**402,503**	**770,901**	**7,232,626**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,226,965	753,773	102,284	134,473	8,217,495
Professional fees				290,786	5,333	16,000	40	312,159
Purchased services				721,866	93,431	827	2,603	818,727
Printing & Postage				248,656	63,615	6,153	4,262	322,685
Depreciation & Amortization				294,845			2,089	296,934
Other expenses				1,392,334	42,544		1,405	1,436,283
Indirect cost allocation & Occupancy				(229,074)	553,492	35,185	4,097	363,700
Total Administrative Expenses				9,946,377	1,512,188	160,448	148,970	11,767,983
Admin Loss Ratio				3.6%	6.1%	7.8%	4.7%	3.8%
INCOME (LOSS) FROM OPERATIONS				(1,006,555)	(4,392,788)	242,055	621,931	(4,535,357)
INVESTMENT INCOME								2,150,661
TOTAL MCO TAX				(769,436)				(769,436)
TOTAL GRANT INCOME				5,288				5,288
OTHER INCOME				75				75
CHANGE IN NET ASSETS				**$ (1,770,629)**	**$ (4,392,788)**	**$ 242,055**	**$ 621,931**	**$ (3,148,770)**
BUDGETED CHANGE IN NET ASSETS				(3,289,595)	(1,088,863)	44,208	147,591	(2,936,659)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 1,518,966	$ (3,303,925)	$ 197,847	$ 474,340	$ (212,111)

July 31, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is ($3.1) million, $0.2 million unfavorable to budget
- Operating deficit is $4.5 million, with a surplus in non-operating income of $1.4 million

Change in Net Assets by Line of Business (LOB) ($ millions)

	MONTH-TO-DATE		
	Actual	Budget	Variance
Medi-Cal	(1.0)	(3.3)	2.3
OCC	(4.4)	(1.1)	(3.3)
OneCare	0.2	0.0	0.2
PACE	0.6	0.1	0.5
Operating	**(4.5)**	**(4.2)**	**(0.3)**
Inv./Rental Inc, MCO tax	1.4	1.3	0.1
Non-Operating	**1.4**	**1.3**	**0.1**
TOTAL	**(3.1)**	**(2.9)**	**(0.2)**

CalOptima - Consolidated
Enrollment Summary
For the One Month Ended July 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
112,390	110,777	1,613	1.5%	SPD	112,390	110,777	1,613	1.5%
510	493	17	3.4%	BCCTP	510	493	17	3.4%
288,238	297,353	(9,115)	(3.1%)	TANF Child	288,238	297,353	(9,115)	(3.1%)
93,572	89,510	4,062	4.5%	TANF Adult	93,572	89,510	4,062	4.5%
3,430	3,505	(75)	(2.1%)	LTC	3,430	3,505	(75)	(2.1%)
244,159	241,029	3,130	1.3%	MCE	244,159	241,029	3,130	1.3%
9,074	11,932	(2,858)	(24.0%)	WCM	9,074	11,932	(2,858)	(24.0%)
751,373	**754,599**	**(3,226)**	**(0.4%)**	**Medi-Cal Total**	**751,373**	**754,599**	**(3,226)**	**(0.4%)**
14,465	**14,134**	**331**	**2.3%**	**OneCare Connect**	**14,465**	**14,134**	**331**	**2.3%**
1,525	**1,378**	**147**	**10.7%**	**OneCare**	**1,525**	**1,378**	**147**	**10.7%**
382	**401**	**(19)**	**(4.7%)**	**PACE**	**382**	**401**	**(19)**	**(4.7%)**
767,745	**770,512**	**(2,767)**	**(0.4%)**	**CalOptima Total**	**767,745**	**770,512**	**(2,767)**	**(0.4%)**
				Enrollment (by Network)				
170,375	168,571	1,804	1.1%	HMO	170,375	168,571	1,804	1.1%
214,083	217,310	(3,227)	(1.5%)	PHC	214,083	217,310	(3,227)	(1.5%)
181,139	183,002	(1,863)	(1.0%)	Shared Risk Group	181,139	183,002	(1,863)	(1.0%)
185,776	185,716	60	0.0%	Fee for Service	185,776	185,716	60	0.0%
751,373	**754,599**	**(3,226)**	**(0.4%)**	**Medi-Cal Total**	**751,373**	**754,599**	**(3,226)**	**(0.4%)**
14,465	**14,134**	**331**	**2.3%**	**OneCare Connect**	**14,465**	**14,134**	**331**	**2.3%**
1,525	**1,378**	**147**	**10.7%**	**OneCare**	**1,525**	**1,378**	**147**	**10.7%**
382	**401**	**(19)**	**(4.7%)**	**PACE**	**382**	**401**	**(19)**	**(4.7%)**
767,745	**770,512**	**(2,767)**	**(0.4%)**	**CalOptima Total**	**767,745**	**770,512**	**(2,767)**	**(0.4%)**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536												10,536	10,357	179
BCCTP	1												1	1	0
TANF Child	54,644												54,644	56,213	(1,569)
TANF Adult	29,033												29,033	28,268	765
LTC	(1)												(1)	2	(3)
MCE	74,441												74,441	71,685	2,756
WCM	1,721												1,721	2,045	(324)
Total	**170,375**												**170,375**	**168,571**	**1,804**
PHCs															
SPD	7,145												7,145	7,023	122
BCCTP													-		0
TANF Child	149,810												149,810	153,891	(4,081)
TANF Adult	11,688												11,688	10,952	736
LTC													-	1	(1)
MCE	39,815												39,815	38,260	1,555
WCM	5,625												5,625	7,183	(1,558)
Total	**214,083**												**214,083**	**217,310**	**(3,227)**
Shared Risk Groups															
SPD	10,264												10,264	10,207	57
BCCTP													-		0
TANF Child	58,289												58,289	61,552	(3,263)
TANF Adult	28,914												28,914	28,257	657
LTC	1												1	2	(1)
MCE	82,747												82,747	81,291	1,456
WCM	924												924	1,693	(769)
Total	**181,139**												**181,139**	**183,002**	**(1,863)**
Fee for Service (Dual)															
SPD	74,615												74,615	73,373	1,242
BCCTP	12												12	17	(5)
TANF Child	1												1	2	(1)
TANF Adult	909												909	946	(37)
LTC	3,079												3,079	3,157	(78)
MCE	1,658												1,658	1,289	369
WCM	13												13	13	0
Total	**80,287**												**80,287**	**78,797**	**1,490**
Fee for Service (Non-Dual - Total)															
SPD	9,830												9,830	9,817	13
BCCTP	497												497	475	22
TANF Child	25,494												25,494	25,695	(201)
TANF Adult	23,028												23,028	21,087	1,941
LTC	351												351	343	8
MCE	45,498												45,498	48,504	(3,006)
WCM	791												791	998	(207)
Total	**105,489**												**105,489**	**106,919**	**(1,430)**
SPD	112,390												112,390	110,777	1,613
BCCTP	510												510	493	17
TANF Child	288,238												288,238	297,353	(9,115)
TANF Adult	93,572												93,572	89,510	4,062
LTC	3,430												3,430	3,505	(75)
MCE	244,159												244,159	241,029	3,130
WCM	9,074												9,074	11,932	(2,858)
Total Medi-Cal MM	**751,373**												**751,373**	**754,599**	**(3,226)**
OneCare Connect	**14,465**												**14,465**	**14,134**	**331**
OneCare	**1,525**												**1,525**	**1,378**	**147**
PACE	**382**												**382**	**401**	**(19)**
Grand Total	**767,745**												**767,745**	**770,512**	**(2,767)**

ENROLLMENT:

Overall, July enrollment was 767,745

- Unfavorable to budget 2,767 or 0.4%
- Increased 8,775 or 1.2% from prior month (PM) (June 2020)
- Increased 11,852 or 1.6% from prior year (PY) (July 2019)

Medi-Cal enrollment was 751,373

- Unfavorable to budget 3,226 or 0.4%
  - Temporary Assistance for Needy Families (TANF) unfavorable 5,053
  - Whole Child Model (WCM) unfavorable 2,858
  - Long-Term Care (LTC) unfavorable 75
  - Medi-Cal Expansion (MCE) favorable 3,130
  - Seniors and Persons with Disabilities (SPD) favorable 1,613
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 17
- Increased 8,604 from PM

OneCare Connect enrollment was 14,465

- Favorable to budget 331 or 2.3%
- Increased 107 from PM

OneCare enrollment was 1,525

- Favorable to budget 147 or 10.7%
- Increased 73 from PM

PACE enrollment was 382

- Unfavorable to budget 19 or 4.7%
- Decreased 9 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the One Month Ending July 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
751,373	**754,599**	**(3,226)**	**(0.4%)**	**Member Months**	**751,373**	**754,599**	**(3,226)**	**(0.4%)**
				Revenues				
278,833,386	285,872,280	(7,038,894)	(2.5%)	Capitation Revenue	278,833,386	285,872,280	(7,038,894)	(2.5%)
-	-	-	0.0%	Other Income	-	-	-	0.0%
278,833,386	**285,872,280**	**(7,038,894)**	**(2.5%)**	**Total Operating Revenue**	**278,833,386**	**285,872,280**	**(7,038,894)**	**(2.5%)**
				Medical Expenses				
91,697,282	95,986,474	4,289,192	4.5%	Provider Capitation	91,697,282	95,986,474	4,289,192	4.5%
53,943,685	57,300,716	3,357,031	5.9%	Facilities Claims	53,943,685	57,300,716	3,357,031	5.9%
31,319,739	32,524,271	1,204,532	3.7%	Professional Claims	31,319,739	32,524,271	1,204,532	3.7%
48,856,852	46,148,336	(2,708,516)	(5.9%)	Prescription Drugs	48,856,852	46,148,336	(2,708,516)	(5.9%)
39,146,868	40,541,546	1,394,678	3.4%	MLTSS	39,146,868	40,541,546	1,394,678	3.4%
4,380,804	4,919,774	538,970	11.0%	Medical Management	4,380,804	4,919,774	538,970	11.0%
548,333	604,006	55,673	9.2%	Reinsurance & Other	548,333	604,006	55,673	9.2%
269,893,563	**278,025,123**	**8,131,560**	**2.9%**	**Total Medical Expenses**	**269,893,563**	**278,025,123**	**8,131,560**	**2.9%**
8,939,822	**7,847,157**	**1,092,665**	**13.9%**	**Gross Margin**	**8,939,822**	**7,847,157**	**1,092,665**	**13.9%**
				Administrative Expenses				
7,226,965	7,306,672	79,707	1.1%	Salaries, Wages & Employee Benefits	7,226,965	7,306,672	79,707	1.1%
290,786	313,097	22,311	7.1%	Professional Fees	290,786	313,097	22,311	7.1%
721,866	1,146,267	424,401	37.0%	Purchased Services	721,866	1,146,267	424,401	37.0%
248,656	443,433	194,777	43.9%	Printing and Postage	248,656	443,433	194,777	43.9%
294,845	458,500	163,655	35.7%	Depreciation & Amortization	294,845	458,500	163,655	35.7%
1,392,334	1,675,666	283,332	16.9%	Other Operating Expenses	1,392,334	1,675,666	283,332	16.9%
(229,074)	(206,883)	22,191	10.7%	Indirect Cost Allocation, Occupancy Expense	(229,074)	(206,883)	22,191	10.7%
9,946,377	**11,136,752**	**1,190,375**	**10.7%**	**Total Administrative Expenses**	**9,946,377**	**11,136,752**	**1,190,375**	**10.7%**
				Operating Tax				
11,699,314	14,617,725	(2,918,411)	(20.0%)	Tax Revenue	11,699,314	14,617,725	(2,918,411)	(20.0%)
12,468,750	14,617,725	2,148,975	0.0%	Premium Tax Expense	12,468,750	14,617,725	2,148,975	0.0%
(769,436)	-	(769,436)	**0.0%**	**Total Net Operating Tax**	(769,436)	-	(769,436)	**0.0%**
				Grant Income				
35,250	-	35,250	0.0%	Grant Revenue	35,250	-	35,250	0.0%
29,963	-	(29,963)	0.0%	Grant expense - Service Partner	29,963	-	(29,963)	0.0%
-	-	-	0.0%	Grant expense - Administrative	-	-	-	0.0%
5,288	-	5,288	**0.0%**	**Total Grant Income**	5,288	-	5,288	**0.0%**
75	**-**	**75**	**0.0%**	**Other income**	**75**	**-**	**75**	**0.0%**
(1,770,629)	**(3,289,595)**	**1,518,966**	**46.2%**	**Change in Net Assets**	**(1,770,629)**	**(3,289,595)**	**1,518,966**	**46.2%**
96.8%	***97.3%***	***0.5%***	***0.5%***	***Medical Loss Ratio***	***96.8%***	***97.3%***	***0.5%***	***0.5%***
3.6%	***3.9%***	***0.3%***	***8.4%***	***Admin Loss Ratio***	***3.6%***	***3.9%***	***0.3%***	***8.4%***

MEDI-CAL INCOME STATEMENT – JULY MONTH:

REVENUES of $278.8 million are unfavorable to budget $7.0 million driven by:

- Unfavorable volume related variance of $1.2 million
- Unfavorable price related variance of $5.8 million due to revenue from WCM

MEDICAL EXPENSES of $269.9 million are favorable to budget $8.1 million driven by:

- Favorable volume related variance of $1.2 million
- Favorable price related variance of $6.9 million due to:
  - Provider Capitation expense favorable variance of $3.9 million due to Proposition 56
  - Facilities Claims expense favorable variance of $3.1 million due to decreased utilization during COVID-19 pandemic
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $1.2 million due to decreased utilization during COVID-19 pandemic
  - Professional Claims expense favorable variance of $1.1 million
  - Offset by Prescription Drugs expense unfavorable variance of $2.9 million due to increased utilization

ADMINISTRATIVE EXPENSES of $9.9 million are favorable to budget $1.2 million driven by:

- Salaries & Benefit expense favorable to budget $0.1 million
- Other Non-Salary expense favorable to budget $1.1 million

CHANGE IN NET ASSETS is ($1.8) million for the month, favorable to budget $1.5 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the One Month Ending July 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,465	**14,134**	**331**	**2.3%**	**Member Months**	**14,465**	**14,134**	**331**	**2.3%**
				Revenues				
2,097,307	2,728,809	(631,502)	(23.1%)	Medi-Cal Capitation Revenue	2,097,307	2,728,809	(631,502)	(23.1%)
17,971,353	18,060,499	(89,146)	(0.5%)	Medicare Capitation Revenue Part C	17,971,353	18,060,499	(89,146)	(0.5%)
4,577,569	5,242,685	(665,116)	(12.7%)	Medicare Capitation Revenue Part D	4,577,569	5,242,685	(665,116)	(12.7%)
-	-	-	0.0%	Other Income	-	-	-	0.0%
24,646,229	**26,031,993**	**(1,385,764)**	**(5.3%)**	**Total Operating Revenue**	**24,646,229**	**26,031,993**	**(1,385,764)**	**(5.3%)**
				Medical Expenses				
11,484,459	11,539,873	55,414	0.5%	Provider Capitation	11,484,459	11,539,873	55,414	0.5%
4,970,703	4,029,234	(941,469)	(23.4%)	Facilities Claims	4,970,703	4,029,234	(941,469)	(23.4%)
1,067,892	940,435	(127,457)	(13.6%)	Ancillary	1,067,892	940,435	(127,457)	(13.6%)
1,846,604	1,575,013	(271,591)	(17.2%)	MLTSS	1,846,604	1,575,013	(271,591)	(17.2%)
6,855,415	5,921,426	(933,989)	(15.8%)	Prescription Drugs	6,855,415	5,921,426	(933,989)	(15.8%)
1,165,545	1,249,747	84,202	6.7%	Medical Management	1,165,545	1,249,747	84,202	6.7%
136,212	215,393	79,181	36.8%	Other Medical Expenses	136,212	215,393	79,181	36.8%
27,526,830	**25,471,121**	**(2,055,709)**	**(8.1%)**	**Total Medical Expenses**	**27,526,830**	**25,471,121**	**(2,055,709)**	**(8.1%)**
(2,880,601)	**560,872**	**(3,441,473)**	**(613.6%)**	**Gross Margin**	**(2,880,601)**	**560,872**	**(3,441,473)**	**(613.6%)**
				Administrative Expenses				
753,773	829,369	75,596	9.1%	Salaries, Wages & Employee Benefits	753,773	829,369	75,596	9.1%
5,333	40,083	34,750	86.7%	Professional Fees	5,333	40,083	34,750	86.7%
93,431	103,412	9,981	9.7%	Purchased Services	93,431	103,412	9,981	9.7%
63,615	106,518	42,903	40.3%	Printing and Postage	63,615	106,518	42,903	40.3%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
42,544	16,861	(25,683)	(152.3%)	Other Operating Expenses	42,544	16,861	(25,683)	(152.3%)
553,492	553,492	-	0.0%	Indirect Cost Allocation	553,492	553,492	-	0.0%
1,512,188	**1,649,735**	**137,548**	**8.3%**	**Total Administrative Expenses**	**1,512,188**	**1,649,735**	**137,548**	**8.3%**
(4,392,788)	**(1,088,863)**	**(3,303,925)**	**(303.4%)**	**Change in Net Assets**	**(4,392,788)**	**(1,088,863)**	**(3,303,925)**	**(303.4%)**
111.7%	***97.8%***	***(13.8%)***	***(14.1%)***	***Medical Loss Ratio***	***111.7%***	***97.8%***	***(13.8%)***	***(14.1%)***
6.1%	***6.3%***	***0.2%***	***3.2%***	***Admin Loss Ratio***	***6.1%***	***6.3%***	***0.2%***	***3.2%***

ONECARE CONNECT INCOME STATEMENT– JULY MONTH:

REVENUES of $24.6 million are unfavorable to budget $1.4 million driven by:

- Favorable volume related variance of $0.6 million
- Unfavorable price related variance of $2.0 million due to Coordinated Care Initiative (CCI) cohort mix and Part D payment reconciliation estimates

MEDICAL EXPENSES of $27.5 million are unfavorable to budget $2.1 million driven by:

- Unfavorable volume related variance of $0.6 million
- Unfavorable price related variance of $1.5 million due to:
  - Facilities Claims expense unfavorable variance of $0.8 million
  - Prescription Drugs expense unfavorable variance of $0.8 million
  - MLTSS expense unfavorable variance of $0.2 million
  - Offset by Provider Capitation expense favorable variance of $0.3 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($4.4) million, unfavorable to budget $3.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the One Month Ending July 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,525	**1,378**	**147**	**10.7%**	**Member Months**	**1,525**	**1,378**	**147**	**10.7%**
				Revenues				
1,410,021	1,154,880	255,141	22.1%	Medicare Part C revenue	1,410,021	1,154,880	255,141	22.1%
641,555	537,236	104,319	19.4%	Medicare Part D revenue	641,555	537,236	104,319	19.4%
2,051,576	**1,692,116**	**359,460**	**21.2%**	**Total Operating Revenue**	**2,051,576**	**1,692,116**	**359,460**	**21.2%**
				Medical Expenses				
556,918	447,180	(109,738)	(24.5%)	Provider Capitation	556,918	447,180	(109,738)	(24.5%)
428,483	458,491	30,008	6.5%	Inpatient	428,483	458,491	30,008	6.5%
95,750	43,072	(52,678)	(122.3%)	Ancillary	95,750	43,072	(52,678)	(122.3%)
51,695	25,895	(25,800)	(99.6%)	Skilled Nursing Facilities	51,695	25,895	(25,800)	(99.6%)
480,805	488,602	7,797	1.6%	Prescription Drugs	480,805	488,602	7,797	1.6%
35,421	45,083	9,662	21.4%	Medical Management	35,421	45,083	9,662	21.4%
1,649,072	**1,508,323**	**(140,749)**	**(9.3%)**	**Total Medical Expenses**	**1,649,072**	**1,508,323**	**(140,749)**	**(9.3%)**
402,503	**183,793**	**218,710**	**119.0%**	**Gross Margin**	**402,503**	**183,793**	**218,710**	**119.0%**
				Administrative Expenses				
102,284	70,029	(32,255)	(46.1%)	Salaries, wages & employee benefits	102,284	70,029	(32,255)	(46.1%)
16,000	16,000	-	0.0%	Professional fees	16,000	16,000	-	0.0%
827	9,750	8,923	91.5%	Purchased services	827	9,750	8,923	91.5%
6,153	8,084	1,931	23.9%	Printing and postage	6,153	8,084	1,931	23.9%
-	537	537	100.0%	Other operating expenses	-	537	537	100.0%
35,185	35,185	-	0.0%	Indirect cost allocation, occupancy expens	35,185	35,185	-	0.0%
160,448	**139,585**	**(20,863)**	**(14.9%)**	**Total Administrative Expenses**	**160,448**	**139,585**	**(20,863)**	**(14.9%)**
242,055	**44,208**	**197,847**	**447.5%**	**Change in Net Assets**	**242,055**	**44,208**	**197,847**	**447.5%**
80.4%	***89.1%***	***8.8%***	***9.8%***	***Medical Loss Ratio***	***80.4%***	***89.1%***	***8.8%***	***9.8%***
7.8%	***8.2%***	***0.4%***	***5.2%***	***Admin Loss Ratio***	***7.8%***	***8.2%***	***0.4%***	***5.2%***

CalOptima
PACE
Statement of Revenues and Expenses
For the One Month Ending July 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
382	**401**	**(19)**	**(4.7%)**	**Member Months**	**382**	**401**	**(19)**	**-4.7%**
				Revenues				
2,400,195	2,524,611	(124,416)	(4.9%)	Medi-Cal Capitation Revenue	2,400,195	2,524,611	(124,416)	(4.9%)
652,085	593,963	58,122	9.8%	Medicare Part C Revenue	652,085	593,963	58,122	9.8%
122,741	142,683	(19,942)	(14.0%)	Medicare Part D Revenue	122,741	142,683	(19,942)	(14.0%)
3,175,020	**3,261,257**	**(86,237)**	**(2.6%)**	**Total Operating Revenue**	**3,175,020**	**3,261,257**	**(86,237)**	**(2.6%)**
				Medical Expenses				
836,720	974,167	137,447	14.1%	Medical Management	836,720	974,167	137,447	14.1%
645,971	758,949	112,978	14.9%	Facilities Claims	645,971	758,949	112,978	14.9%
521,466	638,466	117,000	18.3%	Professional Claims	521,466	638,466	117,000	18.3%
126,458	242,943	116,485	47.9%	Patient Transportation	126,458	242,943	116,485	47.9%
271,574	265,006	(6,568)	(2.5%)	Prescription Drugs	271,574	265,006	(6,568)	(2.5%)
(2,845)	57,965	60,810	104.9%	MLTSS	(2,845)	57,965	60,810	104.9%
4,775	18,039	13,264	73.5%	Other Expenses	4,775	18,039	13,264	73.5%
2,404,119	**2,955,535**	**551,416**	**18.7%**	**Total Medical Expenses**	**2,404,119**	**2,955,535**	**551,416**	**18.7%**
770,901	**305,722**	**465,179**	**152.2%**	**Gross Margin**	**770,901**	**305,722**	**465,179**	**152.2%**
				Administrative Expenses				
134,473	118,427	(16,046)	(13.5%)	Salaries, wages & employee benefits	134,473	118,427	(16,046)	(13.5%)
40	166	126	75.9%	Professional fees	40	166	126	75.9%
2,603	17,776	15,173	85.4%	Purchased services	2,603	17,776	15,173	85.4%
4,262	11,700	7,438	63.6%	Printing and postage	4,262	11,700	7,438	63.6%
2,089	2,070	(19)	(0.9%)	Depreciation & amortization	2,089	2,070	(19)	(0.9%)
1,405	3,597	2,192	60.9%	Other operating expenses	1,405	3,597	2,192	60.9%
4,097	4,395	298	6.8%	Indirect Cost Allocation, Occupancy Expense	4,097	4,395	298	6.8%
148,970	**158,131**	**9,161**	**5.8%**	**Total Administrative Expenses**	**148,970**	**158,131**	**9,161**	**5.8%**
				Operating Tax				
5,669	-	5,669	0.0%	Tax Revenue	5,669	-	5,669	0.0%
5,669	-	(5,669)	0.0%	Premium Tax Expense	5,669	-	(5,669)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
621,931	**147,591**	**474,340**	**321.4%**	**Change in Net Assets**	**621,931**	**147,591**	**474,340**	**321.4%**
75.7%	***90.6%***	***14.9%***	***16.4%***	***Medical Loss Ratio***	***75.7%***	***90.6%***	***14.9%***	***16.4%***
4.7%	***4.8%***	***0.2%***	***3.2%***	***Admin Loss Ratio***	***4.7%***	***4.8%***	***0.2%***	***3.2%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the One Month Ending July 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
44,592	55,000	10,408	18.9%	Purchase services	44,592	55,000	10,408	18.9%
170,912	177,250	6,338	3.6%	Depreciation & amortization	170,912	177,250	6,338	3.6%
18,423	18,500	77	0.4%	Insurance expense	18,423	18,500	77	0.4%
97,713	114,917	17,204	15.0%	Repair and maintenance	97,713	114,917	17,204	15.0%
56,662	41,250	(15,412)	(37.4%)	Other Operating Expense	56,662	41,250	(15,412)	(37.4%)
(388,302)	(406,917)	(18,615)	(4.6%)	Indirect allocation, Occupancy	(388,302)	(406,917)	(18,615)	(4.6%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – JULY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.2 million, favorable to budget $0.2 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.6 million, favorable to budget $0.5 million

CalOptima
Balance Sheet
as of July 31, 2020

ASSETS			LIABILITIES & NET POSITION	
Current Assets			Current Liabilities	
Operating Cash	$458,374,737		Accounts Payable	$86,044,382
Investments	690,461,039		Medical Claims liability	856,938,052
Capitation receivable	325,603,665		Accrued Payroll Liabilities	15,499,386
Receivables - Other	44,422,192		Deferred Revenue	47,248,663
Prepaid expenses	7,166,364		Deferred Lease Obligations	160,858
			Capitation and Withholds	141,513,332
Total Current Assets		**1,526,027,996**	**Total Current Liabilities**	**1,147,404,672**
Capital Assets				
Furniture & Equipment	39,890,502			
Building/Leasehold Improvements	9,779,070			
505 City Parkway West	51,620,226			
	101,289,798			
Less: accumulated depreciation	(53,811,879)			
Capital assets, net		47,477,919	Other (than pensions) post employment benefits liability	25,860,096
Other Assets			Net Pension Liabilities	27,220,125
Restricted Deposit & Other	300,000		Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913			
Board-designated assets:			**TOTAL LIABILITIES**	**1,200,484,893**
Cash and Cash Equivalents	3,775,421			
Long-term Investments	582,703,374		Deferred Inflows	
Total Board-designated Assets	586,478,794		Excess Earnings	506,547
			OPEB 75 Difference in Experience	804,000
			Change in Assumptions	3,728,725
Total Other Assets		643,977,707	OPEB Changes in Assumptions	1,638,000
			Net Position	
TOTAL ASSETS		**2,217,483,622**	TNE	101,080,707
			Funds in Excess of TNE	920,901,820
Deferred Outflows			**TOTAL NET POSITION**	1,021,982,527
Contributions	1,047,297			
Difference in Experience	4,280,308			
Excess Earning	-			
Changes in Assumptions	5,060,465			
OPEB 75 Changes in Assumptions	703,000			
Pension Contributions	570,000			
TOTAL ASSETS & DEFERRED OUTFLOWS		**2,229,144,692**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,229,144,692**

CalOptima
Board Designated Reserve and TNE Analysis
as of July 31, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,471,248				
	Tier 1 - MetLife	159,222,998				
	Tier 1 - Wells Capital	159,645,487				
Board-designated Reserve		479,339,733	318,017,181	497,630,561	161,322,552	(18,290,829)
TNE Requirement	Tier 2 - MetLife	107,139,062	101,080,707	101,080,707	6,058,354	6,058,354
	Consolidated:	**586,478,794**	**419,097,888**	**598,711,268**	**167,380,906**	**(12,232,474)**
	Current reserve level	*1.96*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
as of July 31, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(3,148,770)	(3,148,770)
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	467,846	467,846
Changes in assets and liabilities:		
Prepaid expenses and other	(467,156)	(467,156)
Catastrophic reserves		
Capitation receivable	76,344,169	76,344,169
Medical claims liability	(60,213,968)	(60,213,968)
Deferred revenue	23,824,967	23,824,967
Payable to health networks	(1,467,696)	(1,467,696)
Accounts payable	11,387,936	11,387,936
Accrued payroll	2,010,856	2,010,856
Other accrued liabilities	-	-
Net cash provided by/(used in) operating activities	48,738,184	48,738,184
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(100,994,936)	(100,994,936)
Change in Property and Equipment	(1,291,194)	(1,291,194)
Change in Board designated reserves	(1,594,901)	(1,594,901)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(103,881,031)	(103,881,031)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(55,142,848)	(55,142,848)
CASH AND CASH EQUIVALENTS, beginning of period	$513,517,584	513,517,584
CASH AND CASH EQUIVALENTS, end of period	**458,374,737**	**458,374,737**

BALANCE SHEET – JULY MONTH:

ASSETS of $2.2 billion decreased $27.6 million from June or 1.2%

- Operating Cash decreased $55.1 million due to the timing of cash receipts and disbursements
- Investments increased $101.0 million due to the timing of cash receipts and month-end requirements for operating cash. The advance receipt of August Medicare capitation payment contributes to the overall increase in cash and investments combined total
- Capitation Receivables decreased $77.7 million due to reclassification of Department of Health Care Services (DHCS) payments received from claims liability
- Board Designated Assets increased $1.6 million

LIABILITIES of $1.2 billion decreased $24.5 million from June or 2.0%

- Claims Liabilities decreased $60.2 million due to reclass of DHCS payments received to capitation receivable
- Deferred Revenue increased $23.8 million due to August Medicare capitation received in July
- Accounts Payable increased $11.4 million due to the payment timing of tax

NET ASSETS total $1.0 billion

Homeless Health Initiative and Allocated Funds
as of July 31, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC Mobile Unit Claims	300,000	
FQHC Mobile Unit Staff	270,000	
Home Clinic Access Program (HCAP) Expansion - Telehealth and Clinical Field Team (CFT) On Call Days	1,000,000	
Funds Allocation Total		42,801,087
Program Commitment Balance, available for new initiatives:		$57,198,913

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.
This report only lists Board approved projects.

Budget Allocation Changes Reporting
Changes as of July 31, 2020

Transfer M	Line of Busines	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW - Corporate Application SW - LexixNexis	Maintenance HW/SW - HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
September 3, 2020

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- CY2015 Medicare Part C Contract-level Risk Adjustment Data Validation (CON15 RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit and requested the submission of medical record documentation by July 10, 2020.

  On March 30, 2020, in light of the current public health crisis, CMS suspended CY 2015 RADV audit activities and directed plans to cease making requests for documentation from providers immediately.

  On July 10, 2020, CMS notified CalOptima that it intends to restart the CON15 RADV, on September 14, 2020. Until the suspension is lifted, CMS asks plans to continue not to solicit RADV-related medical records from providers.

- Medicare Data Validation Audit (applicable to OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to conduct a Medicare Data Validation (MDV) audit of all Medicare Parts C and D data reported for the prior calendar year. A kick-off call with CalOptima's independent auditor, Advent, was held on January 6, 2020. Historically, the data validation audit season takes place from March through June each year. The audit includes a webinar validation and source documentation review of Medicare Parts C and D reporting data submitted for the prior calendar year.

Back to Agenda

On April 22, 2020, CalOptima participated in the 2020 Medicare Parts C and D Data Validation Audit, conducted by CMS' contractor, Advent Advisory Group ("Advent"). The following reporting measures were reviewed:

- Part C Special Needs Plans (SNPs) Care Management
- Part D Medication Therapy Management (MTM) Programs

On May 19, 2020, CalOptima submitted the requested documents for the sample selections for each of the required reporting measures. On June 26, 2020, Advent informed CalOptima that it received a final score of 100% for the audit for both its OneCare and OneCare Connect programs. The closing conference was held on July 15, 2020.

2. OneCare Connect

- CY 2019 Performance Measure Validation (PMV):

On May 21, 2020, CMS provided Medicare-Medicaid Plans (MMPs) with an initial notification of upcoming PMV efforts for the following measures:

- MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
- MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

MMPs are required to report various monitoring and performance measures as articulated in the MMP Core Reporting Requirements and MMP State-Specific Reporting Requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS conducts ongoing PMV of select core and state-specific measures.

On July 8, 2020, CalOptima received the document request with a due date of August 11, 2020. CMS held a kick-off call on July 15, 2020 to provide an overview of the upcoming remote webinar review. The PMV webinar is scheduled to be held on September 15, 2020.

B. Regulatory Notices of Non-Compliance

CalOptima did not receive any notices of non-compliance from its regulators for the months of July and August 2020.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt	Effectuation Timeliness within 72 hours of Appeal Decision
December 2019	100%	100%	100%	0%	100%	100%
January 2020	100%	100%	100%	0%	100%	100%
February 2020	100%	100%	100%	25%	100%	100%

- Based on a focused review of ten (10) appeals for the December 2019 file review of Medi-Cal appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of seven (7) appeals for the January 2020 file review of Medi-Cal appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of eight (8) appeals for the February 2020 file review of Medi-Cal appeals, the lower compliance score of 25% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals Resolved within 72 Hours of Receipt
December 2019	N/A	N/A	N/A	N/A	N/A
January 2020	100%	100%	100%	0%	66.67%
February 2020	100%	100%	100%	0%	100%

- Based on a focused review of three (3) appeals for the January 2020 file review of Medi-Cal appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of three (3) appeals for the January 2020 file review of Medi-Cal appeals, the lower compliance score of 66.67% for the resolution of expedited appeals resolved within 72 hours of receipt was due to one (1) untimely appeal.

- Based on a focused review of two (2) appeals for the February 2020 file review of Medi-Cal appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of expedited Medi-Cal appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances Resolved ≤ 30 Calendar Days of Receipt
December 2019	100%	100%	100%	20%	100%
January 2020	100%	100%	100%	20%	90%
February 2020	100%	100%	100%	20%	90%

- Based on a focused review of ten (10) grievances for the December 2019 file review of Medi-Cal grievances, the lower compliance score of 20% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of ten (10) grievances for the January 2020 file review of Medi-Cal grievances, the lower compliance score of 20% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of ten (10) grievances for the January 2020 file review of Medi-Cal grievances, the lower compliance score of 90% for standard resolution of grievances resolved ≤ 30 calendar days of receipt was due to one (1) untimely resolutions.

- Based on a focused review of ten (10) grievances for the February 2020 file review of Medi-Cal grievances, the lower compliance score of 20% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of ten (10) grievances for the February 2020 file review of Medi-Cal grievances, the lower compliance score of 90% for standard resolution of grievances resolved ≤ 30 calendar days of receipt was due to one (1) untimely resolutions.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of standard Medi-Cal grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely grievances.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare GARS: Standard Appeals

Month(s)	Universe Integrity	Classification Score	Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt
December 2019	100%	100%	100%	100%	0%	100%
January 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
February 2020	100%	100%	100%	100%	0%	100%

  - Based on a focused review of one (1) appeal for the December 2019 file review of OneCare standard appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

  - Based on a focused review of two (2) appeals for the February 2020 file review of OneCare standard appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

- OneCare GARS: Payment Reconsideration Appeals

Month(s)	Classification Score	Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved
December 2019	100%	100%	100%	100%	100%
January 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
February 2020	100%	100%	N/A	N/A	100%

  - For the December 2019 file review of OneCare appeals, CalOptima's GARS department received a compliance score of 100% for a focused review of two (2) payment reconsideration appeals.

[6] a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- For the February 2020 file review of OneCare appeals, CalOptima's GARS department received a compliance score of 100% for a focused review of one (1) payment reconsideration appeal.

- OneCare GARS: Standard Grievances

Month(s)	Universe Integrity	Classification Score	Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance Resolved ≤ 30 Calendar Days of Receipt
December 2019	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2020	100%	100%	100%	100%	50%	100%
February 2020	100%	100%	100%	100%	0%	100%

- Based on a focused review of four (4) grievances for the January 2020 file review of OneCare standard grievances, the lower compliance score of 50% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of one (1) grievance for the February 2020 file review of OneCare standard grievances, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely grievances.

- OneCare Connect GARS: Standard Appeals

Month(s)	Universe Integrity	Classification Score	Standard Appeals Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals Resolved ≤ 30 Calendar Days of Receipt
December 2019	100%	100%	100%	100%	0%	100%
January 2020	100%	100%	100%	100%	0%	100%
February 2020	100%	100%	100%	100%	16.67%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Based on a focused review of six (6) appeals for the December 2019 file review of OneCare Connect standard appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of seven (7) appeals for the January 2020 file review of OneCare Connect standard appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of six (6) appeals for the February 2020 file review of OneCare Connect standard appeals, the lower compliance score of 16.67% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

- OneCare Connect GARS: Expedited Appeals

Month(s)	Universe Integrity	Classification Score	Expedited Appeals Verbally Acknowledged ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals Resolved ≤ 72 Hours
December 2019	100%	100%	100%	100%	0%	100%
January 2020	100%	100%	100%	100%	0%	100%
February 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Based on a focused review of two (2) appeals for the December 2019 file review of OneCare Connect expedited appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- Based on a focused review of one (1) appeal for the January 2020 file review of OneCare Connect expedited appeals, the lower compliance score of 0% for the member notice content was due to the content not meeting the required 6th grade reading level.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect expedited appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare Connect GARS: Standard Grievances

Month(s)	Universe Integrity	Classification Score	Standard Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance Resolved ≤ 30 Calendar Days of Receipt
December 2019	100%	100%	90%	100%	10%	100%
January 2020	100%	100%	100%	100%	0%	100%
February 2020	100%	100%	100%	100%	20%	100%

- For the December 2019 file review of OneCare Connect grievances, CalOptima's GARS department received a compliance score of 99.5% based on the overall universe of standard grievances and a compliance score of 83.33% for a focused review of ten (10) grievances.

- Based on a focused review of ten (10) grievances for the December 2019 file review of OneCare Connect standard grievances, the lower compliance score of 90% for the standard grievance acknowledged ≤ 5 calendar days of receipt was due to one (1) untimely acknowledgement notice.

- Based on a focused review of ten (10) grievances for the December 2019 file review of OneCare Connect standard grievances, the lower compliance score of 10% for the member notice content was due to the content of multiple notices not meeting the required 6th grade reading level and the notice not addressing all of the member's complaints.

- Based on a focused review of ten (10) grievances for the January 2020 file review of OneCare Connect standard grievances, the lower compliance score of 0% for the member notice content was due to the content of multiple notices not meeting the required 6th grade reading level.

- Based on a focused review of ten (10) grievances for the February 2020 file review of OneCare Connect standard grievances, the lower compliance score of 20% for the member notice content was due to the content of multiple notices not meeting the required 6th grade reading level and one (1) non-discrimination letter not using the most current version.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of OneCare Connect standard grievances. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely grievances.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

2. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified	Letter Score for Modified	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2020	62%	84%	89%	95%	95%	93%	98%	100%	67%	84%	Nothing to Report	Nothing to Report	Nothing to Report
April 2020	89%	78%	95%	80%	90%	89%	94%	84%	69%	80%	Nothing to Report	Nothing to Report	Nothing to Report
May 2020	90%	95%	98%	95%	95%	90%	96%	55%	84%	95%	Nothing to Report	Nothing to Report	Nothing to Report

- CalOptima's Audit & Oversight (A&0) department, with approval from the Audit & Oversight Committee and Compliance Committee, suspended the monthly monitoring of UM Medi-Cal files for the months of March through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. The Audit & Oversight department continued to monitor two (2) health networks under sanction.

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness. One (1) out of the ten (10) files received from the health network was deficient due to a failure to meet the timeframe for provider initial notification (24 hours)

- Based on the overall universe of Medi-Cal authorizations for March 2020, the two (2) CalOptima health networks under sanction received an overall compliance score of 99.89% for timely processing of routine authorization requests and a compliance score of 97.97% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight department issued requests for corrective action plans (CAPs) to the two (2) health networks for deficiencies identified during the review of prior authorization requests. The Audit & Oversight department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

3. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
March 2020	100%	N/A	100%	100%	95%	100%	84%	98%
April 2020	70%	N/A	99%	95%	99%	Nothing to Report	Nothing to Report	Nothing to Report
May 2020	93%	N/A	72%	100%	84%	100%	100%	92%

- CalOptima's Audit & Oversight (A&O) department, with approval from the Audit & Oversight Committee and Compliance Committee, suspended the monthly monitoring of OneCare UM files for the months of March through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. The Audit & Oversight department continued to monitor two (2) health networks under sanction.

- Based on a focused review of select files, sixteen (16) of the twenty-six (26) files received from the two (2) health networks were deficient due to their failure to provide letters with a description of services in lay language.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to the two (2) health networks for deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

4. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
March 2020	100%	67%	94%	100%	93%	88%	46%	57%	Nothing to Report	Nothing to Report	Nothing to Report
April 2020	100%	N/A	97%	100%	100%	67%	100%	93%	75%	75%	89%
May 2020	100%	N/A	84%	100%	82%	100%	92%	92%	65%	89%	97%

- CalOptima's Audit & Oversight (A&O) department, with approval from the Audit & Oversight Committee and Compliance Committee, suspended the monthly monitoring of OneCare Connect UM files for the months of March through May 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. The Audit & Oversight department continued to monitor two (2) health networks under sanction.

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness. Five (5) of the seven (7) files received from the health network were deficient due to the health network reporting modified approvals instead of modified denials.

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making. One (1) of the two (2) files received from the health network was deficient due to a failure to cite criteria for clinical decision making.

- Based on a focused review of select files, two (2) health networks drove the lower compliance letter score. Five (5) of the thirty-three (33) files received from the two (2) health networks were deficient due to the following reasons:
  - Failure to provide letter with description of services in lay language
  - Failure to provide a reason for why the request did not meet the criteria

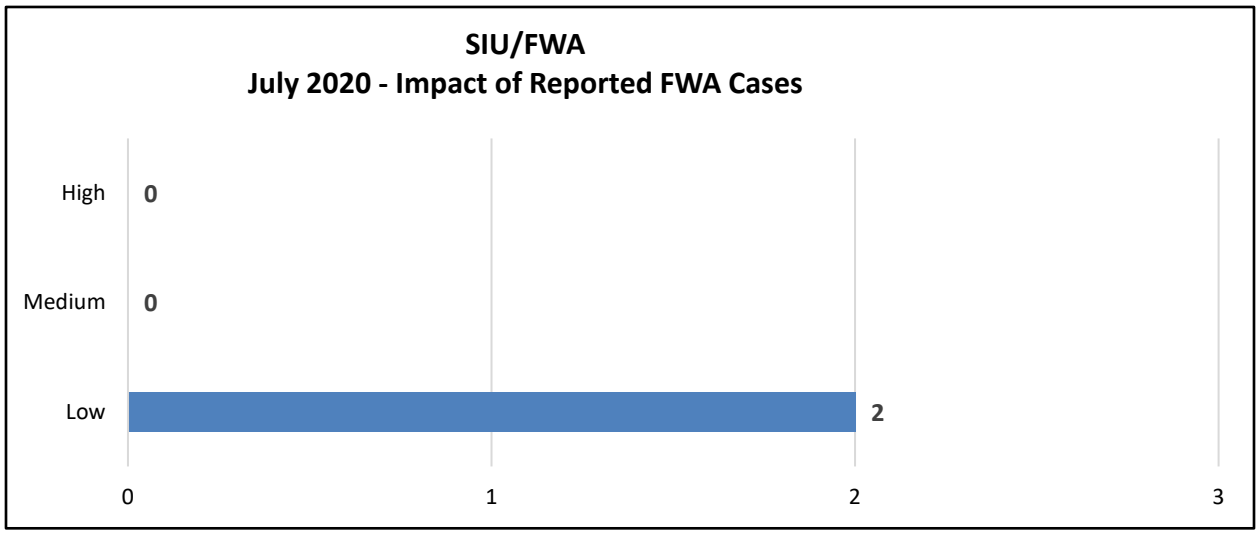
- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to both health networks for the deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in July 2020)



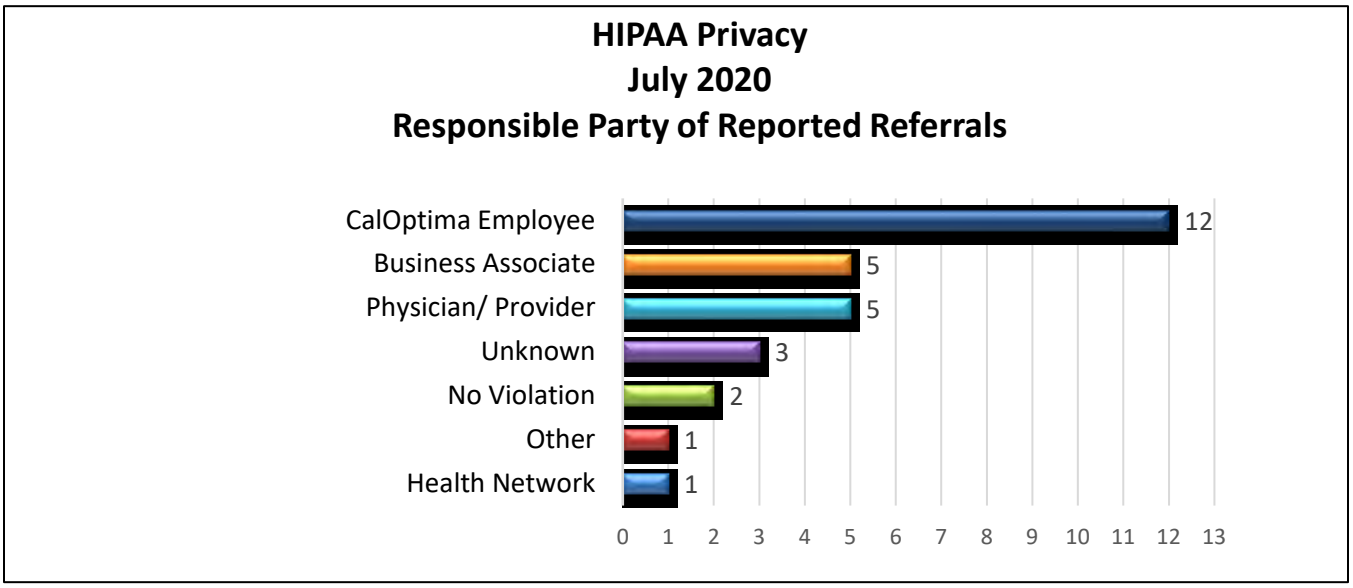
Note: The two (2) FWA cases are related to allegations of medically unnecessary services.

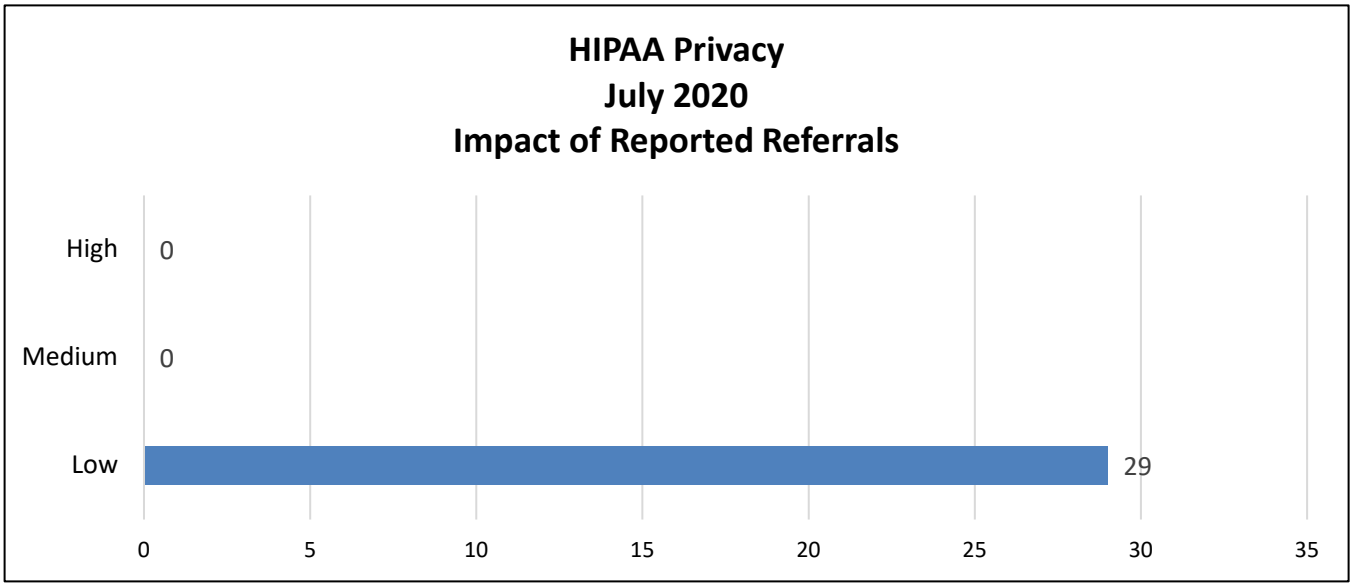
Total Number of Referrals Reported to DHCS (State)	2
Total Number of Referrals Reported to DHCS and MEDIC	0
Total Number of Referrals Reported	**2**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

E. Privacy Update: (July 2020)





Total Number of Referrals Reported to DHCS (State)	29
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**29**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

August 18, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: August Board of Directors Report

Confirmed cases of COVID-19 in the United States have topped 5 million with deaths exceeding 170,000. Meanwhile, amid calls for additional relief and a continuation of the CARES Act enhanced unemployment benefits that expired at the end of July, congressional Democrats and the Trump Administration have deadlocked in negotiations over the next COVID-19 package. This report covers congressional developments through August 18, 2020.

COVID-19 Relief Package

Senate Republicans on July 27 released their "Phase 4" COVID-19 relief package, the Health, Economic Assistance, Liability Protection and Schools (HEALS) Act, as a set of eight individual bills that touch on a variety of areas, including health care, education, liability, tax relief, supply chain resiliency, small business, and unemployment. The package includes a second round of economic impact payments for individuals; a supplemental unemployment benefit of $200 per week through September 2020; a second round of Paycheck Protection Program (PPP) loans for small businesses; an increased Employee Retention Tax Credit (ERTC); liability protections for schools, health care providers, and employers; and over $300 billion in emergency appropriations. With respect to health care, the package includes: an additional $25 billion for the Provider Relief Fund; $16 billion for COVID-19 testing and contact tracing; $20 billion for the Biomedical Advanced Research and Development Authority (BARDA) for vaccine, therapeutic, and diagnostic development; extension of Medicare telehealth flexibilities through at least December 31, 2021; and repayment date extensions for Medicare Advance/Accelerated Payments.

The HEALS Act also includes a number of supply chain proposals, such as requiring the Strategic National Stockpile (SNS) to purchase only domestically produced personal protective equipment (PPE) and other medical supplies and establishing a 30 percent investment tax credit for U.S. manufacturers of PPE. The Act includes several provisions to create and expand state stockpiles of critical supplies.

Unlike the House-passed Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act favored by Democrats, the HEALS Act does not require the creation of a national testing/tracing program. Notably, unlike HEROES, the HEALS Act does not contain any

Back to Agenda

provisions relating to Medicaid, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, Affordable Care Act (ACA) Special Enrollment, or private insurance coverage for COVID-19 treatment.

The HEALS Act was panned by congressional Democrats upon its release. In particular, Democrats are calling for an extension of enhanced unemployment benefits at $600 per week, the same level as the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and additional relief funding for state and local governments. Democrats have also raised concern about the liability protections in the bill. Senate Republicans initially proposed a separate measure to extend enhanced unemployment benefits, but Democrats want any such extension to be part of a comprehensive relief package. Senate Minority Leader Chuck Schumer (D-NY), House Speaker Nancy Pelosi (D-CA), White House Chief of Staff Mark Meadows, and Treasury Secretary Steven Mnuchin met several times to discuss a way forward on the "Phase 4" package, but as of August 9 talks have been at a standstill.

Reports suggest Senate Republicans are planning a slimmed down version of their proposal that would include a $300 per week supplemental unemployment benefit, liability protections, small business relief, and additional funding for the U.S. Postal Service. Senate Majority Leader Mitch McConnell (R-KY) has not signaled that he would call Members back from the August recess, however.

Citing the lack of progress on a legislative package, President Trump on August 8 signed four executive orders that aim to provide limited economic relief to Americans. An order on unemployment insurance extends the CARES Act benefit while lowering the weekly enhancement from $600 to $400 and requiring states to cover 25 percent of the cost. A housing order directs federal agencies to review existing authorities and resources that could be used to prevent evictions and foreclosures. An order on student loans extends until December 31 the CARES Act policy that waives interest and temporarily halts payments on federal loans. Finally, an order on payroll taxes allows employers to defer collection of payroll taxes through December 31 for employees making less than $100,000 annually.

FY 2021 Appropriations

On July 24, the House voted 224-189 to pass its first appropriations "minibus" (H.R. 7608), which contained the Agriculture-FDA, Interior-Environment, Military Construction-VA, and State-Foreign Operations spending measures. On July 31, the House voted 217-197 to pass its second minibus, comprised of the Commerce-Justice-Science, Defense, Energy-Water, Financial Services, Homeland Security, Labor-Health and Human Services, and Transportation-HUD spending bills. House Republicans criticized Democratic policy riders in the appropriations packages, as well as the nearly $250 billion in emergency spending across the 12 spending

Back to Agenda

measures. The Committee Report accompanying the Labor-HHS bill included a number of Medicaid provisions, including prohibiting the implementation of a proposed rule that would allow states to opt out of the requirement to cover nonemergency medical transportation for Medicaid beneficiaries, and prohibiting implementation of a final rule related to reassignment of Medicaid provider claims. The report also contains language on homelessness that directs the Department of Health and Human Services (HHS) to report on how waivers could allow Medicaid funds to be used for affordable housing and resident services.

In contrast to the House's rapid pace, the Senate has yet to mark up any appropriations bill, either in Subcommittee or Full Committee. It is likely that a Continuing Resolution (CR) of some length will be needed to keep the government funded when the fiscal year expires on September 30. The House was set to return the day after Labor Day, but is now not expected to vote on a funding package until the week of September 14.

Telehealth

On July 16, Members of the House Telehealth Caucus introduced the Protecting Access to Post-COVID-19 Telehealth Act of 2020 (H.R. 7663). The bill would eliminate geographic/originating site restrictions in Medicare and make permanent the telehealth flexibilities granted to federally qualified health centers and rural health clinics during the pandemic. The measure also would authorize the Centers for Medicare and Medicaid Services (CMS) to extend reimbursement for telehealth services for 90 days beyond the end of the public health emergency. On August 6, the House Ways and Means Committee Rural and Underserved Communities Task Force hosted a roundtable discussion on telehealth. Members on both sides of the aisle expressed interest in extending some telehealth flexibilities beyond the end of the PHE, while also discussing ways to structure payment to avoid overutilization.

On August 3, President Trump signed an Executive Order that directs HHS to review the Medicare telehealth flexibilities offered during the public health emergency (PHE) and to propose a regulation to extend some of these policies beyond the end of the PHE. The order also calls for HHS to announce a new model to test innovative payment mechanisms in support of rural health care. According to the order, this model "should give rural providers flexibilities from existing Medicare rules, establish predictable financial payments, and encourage the movement into high-quality, value-based care."

Drug Pricing Executive Orders

The President on July 24 released several executive orders aimed at lowering prescription drug prices. The first order directs health centers to pass along discounts on insulin and epinephrine products to patients; the second allows state plans for safe importation of prescription drugs; and

Back to Agenda

the third proposes to eliminate drug rebates in Medicare Part D. The White House also announced a potential fourth executive order establishing international reference pricing for certain Medicare Part B drugs. The Administration is currently negotiating with pharmaceutical industry representatives on alternative solutions, and will release the fourth order on August 24 if no agreement has been reached.

Back to Agenda

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

August 7, 2020

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

Governor Newsom has walked a political tightrope since March when he issued a first-in-the-nation order for Californian's to shelter in place. The shelter in place order was highly effective at reducing the rate at which COVID-19 spread in California. At the same time, it brought economic devastation on a level that pales in comparison to anything experienced in recent memory.

As we've reported previously, Governor Newsom faced increasing pressure from a willful population and defiant counties who were seeking to reopen. Bowing to this pressure, the state loosened its guidelines enough to allow a more rapid reopening and return to work for Californians. For a few weeks in June and July, restaurants, bars, salons, and gyms were reopened.

With California's COVID-19 infection and mortality rates spiking, however, 97% of the state's population are once again restricted from visiting these businesses. The virus has made its way into even the most remote of California's Counties. Editorial boards, medical professionals, and some in the state Legislature have started encouraging the Governor to pursue a more aggressive shelter in place order, once again limiting activity outside of the home to essential business.

61% of California respondents recently told the Berkley Institute for Governmental Studies that California has reopened too fast. With those numbers as well as pressure to issue more restrictive orders coming from politicians, the press, and medical professionals it may seem strange that the Governor has not already re-imposed a more severe shelter in place order.

However, in Sacramento it is widely recognized that the path to Newsom's political future runs through Presidential battleground states. According to a Change Research poll 57% of likely Florida voters believe their state has reopened too quickly. Results were lower in Arizona (51%), Wisconsin (48%), North Carolina (38%), and Michigan (28%). The challenge for the Governor may be finding a path forward that allows him to credibly claim to have found a middle ground for his state that limited the spread of the virus while protecting against greater economic hardship. That claim must pass muster not just with California's more liberal electorate, but in middle America.

Budget and Taxes

The Governor must also grapple with the impact the economic crisis has had on the budget. As reported previously, the Governor and the Legislature closed the state's $54 billion budget gap with a tenuous agreement that relies on the hope that the federal government will backfill lost revenue for the state. If federal money is not forthcoming, the enacted budget will likely worsen the state's finances in future budget years.

Public employee unions and some Democrats in the Legislature believe taxes are the answer to the state's financial woes. Even before the onset of the pandemic, these groups were pursuing an initiative to split the property tax roll. Proposition 15 would carve some commercial properties out of the property tax protections approved by voters under Proposition 13 in 1978. If passed Prop. 15 would raise $6.5-$11.5 billion in new revenue for local governments and schools.

While Prop. 15 will be on the ballot in November, legislators are also pursuing new taxes. Assemblymember Miguel Santiago has introduced legislation that would impose an additional 1% tax on those earning more than $1 million, 3% on those earning more than $2 million, and 3.5% on those earning more than $5 million. Another bill, AB 398 (Chu) would assess a $275 per employee tax on businesses with over 500 employees.

On paper, Democrats have more than enough votes to meet the 2/3 threshold for the Legislature to pass new taxes. In reality, many of the Democrats who make up the "supermajority" are moderates who won their seats from Republicans in competitive districts. For these moderates, a vote for increased taxes is a big risk this close to an election. It is also true that state revenue is extremely volatile because California already relies disproportionately on high income earners. Doubling down on that means the state will continue to face rapid revenue swings during future recessions.

A competing group composed of moderate and traditional Democrats alike have proposed a "non-tax" alternative to raise revenue. As we noted last week, Senator Hertzberg and a number of his colleagues have proposed to raise $100 billion through "securitization" of existing revenue streams and incentivizing taxpayers to pay future taxes early. Though innovative, there are scant details to prove that the proposal could raise so much revenue and no bills have been introduced thus far. Given that, it seems unlikely that much progress is made on this idea in 2020. Nevertheless, it represents a non-tax alternative for raising revenue.

Thus far, the Governor has not weighed in on any of the legislative proposals. He and the Legislature must weigh the politics of imposing new taxes during one of the worst economic crises of modern times against the state's looming budget crises.

Back to Agenda

2019–20 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 266 McCollum	**Paycheck Protection Program and Health Care Enhancement Act:** Authorizes $483 billion to replenish segments of the CARES Act, expand coronavirus testing, and provide more support to hospitals and providers during this pandemic. Of the $483 billion, this bill includes: ■ $310 billion in funding for the Small Business Administration's PPP; ■ $10 billion for Economic Injury Disaster Loans; ■ $75 billion for the provider relief fund, managed by the Department of Health and Human Services, to cover treatment for COVID-19 patients and lost revenue from canceled elective procedures; and ■ $25 billion to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests.	**04/24/2020** Signed into law **04/23/2020** Passed the House **04/21/2020** Passed the Senate **01/08/2019** Introduced	CalOptima: Watch
H.R. 748 Courtney	**CARES Act:** Authorizes $2.2 trillion in spending for health care and employment-related interventions. This includes: ■ $1.5 billion to support the purchase of personal protective equipment, lab testing, and other activities; ■ $127 billion to provide grants to hospitals, public entities, and nonprofits, and Medicare and Medicaid suppliers and providers to cover unreimbursed health care related expenses or lost revenues due to COVID-19; ■ $1.32 billion in supplemental funding for community health centers; ■ $955 million to support nutrition programs, home and community-based services, support for family caregivers, and expanded oversight for seniors and individuals with disabilities; ■ $945 million to support research on COVID-19; and ■ $425 million to increase mental health services.	**03/27/2020** Signed into law **03/27/2020** Passed the House **03/25/2020** Passed the Senate **01/24/2019** Introduced	CalOptima: Watch
H.R. 6201 Lowey	**Families First Coronavirus Response Act:** Allocates billions of federal funding support related to COVID-19. Funds are to be utilized for an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2%, emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid and other provisions. Of note, on March 6, 2020, President Trump signed into law an emergency supplemental funding package of $8.3 billion for treating and preventing the spread of COVID-19.	**03/18/2020** Signed into law **03/17/2020** Passed the Senate **03/14/2020** Passed the House **03/11/2020** Introduced	CalOptima: Watch
H.R. 6462 Cisneros, Gallegos	**Emergency Medicaid for Coronavirus Treatment Act:** Would expand Medicaid eligibility to any American diagnosed with COVID-19 or any other illness that rises to the level of a presidential national emergency declaration. Additionally, would require Medicaid coverage for all COVID-19 treatment and testing to continue even after the national emergency is over.	**04/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 6666 Rush	**COVID-19 Testing, Reaching, and Contacting Everyone (TRACE) Act:** Would authorize the Centers for Disease Control and Prevention (CDC) to award grants for testing, contact tracing, monitoring, and other activities to address COVID-19. Those eligible to receive grant funding would include federally qualified health centers, nonprofit organizations, and certain hospitals and schools. Additionally, would allocate $100 billion for fiscal year 2020 for the disbursement of CDC grant funds.	**05/01/2020** Introduced	CalOptima: Watch
SB 89 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19:** Appropriates $500 million General Fund by amending the Budget Act of 2019. Funds will be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, authorizes additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
AB 117 Ting	**Emergency Budget Response to COVID-19 at Schools:** Similar to SB 117, appropriate $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds would be distributed by the Superintendent of Public Instruction.	**03/16/2020** Amended and referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch
SB 117 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19 at Schools:** Similar to AB 117, appropriates $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds will be distributed by the Superintendent of Public Instruction.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
SB 275 Pan, Leyva	**Personal Protective Equipment:** Would require the State Department of Public Health to establish a personal protective equipment (PPE) stockpile to ensure an adequate supply of PPE for health care workers and essential workers. Would require the stockpile to have enough supplies for no less than a 90-day pandemic or other health emergency. Additionally, would require providers, clinics, health facilities, and home health agencies to maintain a stockpile of PPE.	**06/17/2020** Referred to Committee on Business and Professions **05/02/2019** Passed Senate floor; Referred to Assembly floor **02/13/2019** Introduced	CalOptima: Watch

STATE BUDGET BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 79	**Human Services:** Enacts human services trailer bills in the California 2020-2021 budget. ■ Department of Developmental Services supplemental rate increases for specified providers including, independent living programs, infant development programs, and early start specialized therapeutic services ■ In-Home Supportive Services reassessment extensions due to delays related to COVID-19 and Governor Newsom's executive state of emergency order	**06/29/2020** Signed into law **06/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 80	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal managed care capitated payment rate reduction of 1.5 percent for the 18-month bridge period ■ Implementation of a Medi-Cal risk corridor for the 18-month bridge period ■ Prop 56 value-based payments and supplemental payments ■ Extension of the Medi-Cal 2020 Demonstration ■ 340B Supplemental Payment Pool for non-hospital clinics ■ Expansion of full-scope Medi-Cal to seniors, regardless of immigration status ■ Extension of coverage for COVID-19 to uninsured individuals ■ Health Care Payment Data Program ■ Reimbursement for medication-assisted treatment services	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 81	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal rate reimbursement methodology adjustments for skilled nursing facilities during the COVID-19 pandemic ■ Implementation of the skilled nursing facility quality assurance fee ■ County access to Mental Health Services Act funds for additional support related to COVID-19	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 83	**Housing:** Enacts housing trailer bills in the California 2020-2021 budget. ■ Funding to continue Project Roomkey ■ Bypassing certain California Environmental Quality Act (CEQA) regulations related to Project Roomkey	**6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 89	**Fiscal Year 2020-2021 California State Budget:** Enacts a $202.1 billion spending plan for Fiscal Year 2020-2021, with General Fund spending at $133.9 billion. The following included within the state budget will have a direct impact to Medi-Cal: ■ Funding to address Medi-Cal caseloads ■ Provisions to maintain Community Based Adult Services, the Multipurpose Senior Services Program, and other optional benefits ■ Funding to address the COVID-19 pandemic	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

AFFORDABLE CARE ACT

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1425 Craig	**Patient Protection and Affordable Care Enhancement Act (PPACEA):** Would, among other things, lower health care costs through fair drug price negotiations, provide additional protections for those with preexisting health conditions, and offer 100 percent federal matching funds for states that choose to expand Medicaid under the Affordable Care Act. The bill also would reduce the Federal Medical Assistance Percentages for the fourteen remaining non-expansion states and permanently authorize the Children's Health Insurance Program.	**06/30/2020** Passed the House; Referred to the Senate **02/22/2020** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 910 Wood	**Mental Health Services Dispute Resolution:** Would provide the Department of Health Care Services (DHCS) more authority to resolve coverage disputes between the specialty mental health plan (MHP) and the Medi-Cal managed care plan (MCP) if the MHP and the MCP are unable to do so within 15 days. Would require the MHP and the MCP to continue to provide mental health services during the DHCS review period. DHCS would have no more than 30 days to resolve the dispute to determine which agency is responsible for that Medi-Cal beneficiary.	**06/23/2020** Referred to Senate Committee on Health **01/30/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2266, would authorize MHSA funds to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The authorization would apply across the state. Additionally, would require the county that elects to utilize MHSA funding for this purpose to report the number of people assessed for cooccurring mental health and substance use disorders and the number of those assessed who only have a substance use disorder to the Department of Health Care Services.	**06/23/2020** Referred to Senate Committee on Health **06/02/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch
AB 2266 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2265, would authorize MHSA funds to be used for a pilot program to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The pilot program would take place in 10 counties, including the County of Orange, beginning January 1, 2022 and ending on December 31, 2026.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2576 Gloria	**Mental Health Services Act (MHSA) Use of Funds for Homelessness:** Would require a county to seek stakeholder input when establishing a plan to reallocate the use of MHSA funds. Additionally, would require counties utilizing MHSA funds for the provision of mental health services for those experiencing homelessness to report to the Legislature, each year, the number of individuals receiving services.	**07/01/2020** Referred to Senate Committee on Health **06/15/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 803 Beall	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Would create the Certified Peer Support Specialist (PSS) certificate program. Would allow parents, peers, and family, 18 years of age or older and who have experienced a mental illness and/or a substance use disorder, to become a PSS. A PSS would be able to provide non-medical mental health and substance abuse support services to a Medi-Cal beneficiary receiving specialty mental health services or Drug Medi-Cal services in any county if that county opts in to provide peer support specialist services and fund the non-federal share of those services. This would also require the county to develop and implement billing codes, reimbursement rates, and claim requirements for the PSS program. Additionally, would require the Department of Health Care Services to include PSS as a Medi-Cal provider type, no sooner than January 1, 2022. If federally approved, the peer-support program would be funded for Fiscal Years 2020-21 and 2021-22 by the Mental Health Services Act.	**08/04/2020** Passed Assembly Committee on Health; Referred to Assembly Committee on Appropriations **06/24/2020** Passed Senate floor; Referred to Assembly floor **01/08/2020** Introduced	CalOptima: Watch LHPC: Support Orange County Board of Supervisors: Support
SB 1254 Moorlach	**Capacity Determinations and Appointments of Guardians Ad Litem for Mentally Ill Adults Without a Conservator:** Would establish an additional procedure for the appointment of a guardian ad litem for a person who lacks the capacity to make rational informed decisions regarding medical care, mental health care, safety, hygiene, shelter, food, or clothing with a rational thought process due to a mental illness, defect, or deficiency. The bill would authorize certain persons to petition the court for the appointment of a guardian ad litem under these provisions.	**05/22/2020** Hearing canceled at the request of the author. **05/11/2020** Referred to Committee on Judiciary **02/21/2020** Introduced	CalOptima: Watch

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Would require the Medi-Cal managed care plan (MCP) to conduct blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age. This would require the MCP to: ■ Establish a monitoring system; ■ Identify, on a quarterly basis, every beneficiary under six years of age or younger that has missed a blood screening test; ■ If a test was missed, identify at what age the test was missed and notify the beneficiary's health care provider; ■ Contract with providers qualified to conduct any blood level screening tests; and ■ Notify the beneficiary's parent or guardian that the beneficiary is eligible for blood lead screening tests. Additionally, if a child two to six years of age does not have medical records stating the completion of a blood lead screening test, the MCP would be required to provide at least one blood lead screening test. The MCP would also be required to report to the Department of Health Care Services (DHCS) the number of beneficiaries aged one and two who have received a blood lead screening test and of any associated case management services provided.	**08/01/2020** Passed Senate Committee on Health; Referred to Senate Committee on Appropriations **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2277 Salas	**Blood Lead Screening Tests Contracted Providers:** Would require the Medi-Cal managed care plan (MCP) to identify beneficiaries who have missed a blood screening test at both 12 and 24 months of age and impose requirements of the contracted provider to conduct blood lead screenings tests for those eligible to receive such tests. Would require the MCP to remind the contracted provider to conduct blood lead screening tests on a quarterly basis and to notify the beneficiary's parent, parents, guardian, or other person responsible for their care that the beneficiary is eligible to receive a blood screening test.	**07/01/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch
AB 2278 Quirk	**Childhood Lead Poisoning Prevention Health Plan Identification:** Would require the name of the health plan financially liable for conducting blood lead screenings tests to be reported by the laboratory to the Department of Health Care Services once the screening test has been completed. The name of the health plan is to be reported for each Medi-Cal beneficiary who receives the blood lead screen tests.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2279 Garcia	**Childhood Lead Poisoning Prevention Risk Factors:** Would require the following risk factors be included in the standard risk factors guide, which are to be considered during each beneficiary's periodic health assessment: ■ A child's residency or visit to a foreign country ■ A child's residency in a high-risk ZIP Code ■ A child's relative who has been exposed to lead poisoning ■ The likelihood of a child placing nonfood items in the mouth ■ A child's proximity to current or former lead-producing facilities ■ The likelihood of a child using food, medicine, or dishes from other countries	**06/23/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch
AB 2422 Grayson	**Blood Lead Screening Tests Medi-Cal Identification Number:** Would require the Medi-Cal identification number to be added to the list of patient identification information collected during each blood test. Would require the laboratory conducting the blood lead screening tests to report all patient identification information to the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch
SB 1008 Leyva	**Childhood Lead Poisoning Prevention Act Online Registry:** Would require the Department of Public Health to design, implement, and maintain an online lead information registry available to the general public. Would require the information registry to include items such as the location and status of properties being inspected for lead contaminants.	**05/12/2020** Rescinded due to shortened 2020 Legislative Calendar **03/05/2020** Referred to Committees on Health; Judiciary **02/14/2020** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2042 Wood	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to SB 916, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2055 Wood	**CalAIM Drug Medi-Cal and Behavioral Health:** Would require the Department of Health Care Services to establish the Behavioral Health Quality Improvement Program. The Behavioral Health Quality Improvement Program would be responsible for providing support to entities managing the Drug Medi-Cal program as they prepare for any changes directed by the CalAIM initiative. Additionally, would establish a voluntary intergovernmental transfer (IGT) program relating to substance use disorder treatment provided by counties under the Drug Medi-Cal program. The IGT program would fund the nonfederal share of supplemental payments and to replace claims based on certified public expenditures.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2170 Blanco Rubio	**CalAIM Medi-Cal Eligibility for Juveniles Who are Incarcerated:** Would require the county welfare department to conduct a redetermination of eligibility for juveniles who are incarcerated so that, if eligible, their Medi-Cal would be reinstated immediately upon release.	**02/20/2020** Referred to Committee on Health **02/11/2020** Introduced	CalOptima: Watch
SB 910 Pan	**CalAIM Population Health Management:** Would require Medi-Cal managed care plans (MCPs) to implement the population health management program for those deemed eligible, effective January 1, 2022. Would require the Department of Health Care Services to utilize an external quality review organization (EQRO) to evaluate the effectiveness of the enhanced care management and in-lieu-of services provided to beneficiaries by each MCP. Additionally, would require each MCP to consult with stakeholders, including, but not limited to, county behavioral health departments, public health departments, providers, community-based organizations, consumer advocates, and Medi-Cal beneficiaries, on developing and implementing the population health management program.	**03/16/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
SB 916 Pan	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to AB 2042, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**03/16/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**10/17/2019** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
AB 1904 Boerner Horvath	**Maternal Physical Therapy:** Would include pelvic floor physical therapy for women post-pregnancy as a Medi-Cal benefit.	**01/17/2020** Referred to Committee on Health **01/08/2020** Introduced	CalOptima: Watch
AB 1965 Aguiar-Curry	**Human Papillomavirus (HPV) Vaccine:** Would expand comprehensive clinical family planning services under the program to include the HPV vaccine for persons of reproductive age.	**03/17/2020** Hearing canceled at the request of the author **01/30/2020** Referred to Committee on Health **01/21/2020** Introduced	CalOptima: Watch
AB 2258 Reyes	**Doula Care:** Would require full-spectrum doula care to be included as a covered benefit for pregnant and postpartum Medi-Cal beneficiaries. The program would be established as a 3-year pilot program in 14 counties, including the County of Orange, beginning July 1, 2021. Prior authorization or cost-sharing to receive doula care would not be required.	**02/20/2020** Referred to Committee on Health **02/13/2020** Introduced	CalOptima: Watch

DENTAL

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2535 Mathis	**Denti-Cal Education Pilot Program:** Would establish a 5-year pilot program to provide education and training to Denti-Cal providers providing care to individuals who attend a regional center and are living with a developmental disability. Additionally, Denti-Cal providers who participate in the pilot program and complete the required continuing education units would be eligible for a supplemental provider payment. The supplemental provider payment amount has yet to be defined by the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services.	**07/02/2019** Hearing canceled at the request of the author **06/06/2019** Referred to Senate Committee on Health **05/28/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
AB 526 Petrie-Norris	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to SB 1073, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**08/30/2019** Senate Committee on Appropriations; Held under submission **06/27/2019** Passed Senate Committee on Health **05/23/2019** Passed Assembly floor **02/13/2019** Introduced	CalOptima: Watch
AB 683 Carrillo	**Adjusting the Assets Test for Medi-Cal Eligibility:** Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment, effective July 1, 2020. Additionally, would prohibit the Department of Health Care Services from using an asset and resource test when determining eligibility for Medi-Cal enrollment when the individual is enrolled in the Medicare Shared Savings Program, effective January 1, 2020.	**06/23/2020** Referred to Senate Committee on Health **01/20/2020** Passed Assembly floor; Referred to Senate floor **02/15/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older. The financial costs for In-Home Supportive Services is estimated to cost $13 million General Fund.	**09/13/2019** Held in Assembly **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
SB 1073 Gonzalez	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to AB 526, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**04/03/2020** Referred to Committee on Health **02/18/2020** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to Committee on Health, Education, Labor, and Pensions	CalOptima: Watch
AB 1907 Santiago, Gipson, Quirk-Silva	**California Environmental Quality Act (CEQA) Exemption for Emergency Shelters and Supportive Housing:** Would exempt the development of emergency shelters, supportive housing or affordable housing by a public agency from CEQA regulations, expiring on December 31, 2028.	**05/13/2020** Hearing canceled at the request of the author **01/30/2020** Referred to Committees on Natural Resources; Housing and Community Development **01/08/2020** Introduced	CalOptima: Watch
AB 2295 Quirk-Silva	**Fairview Developmental Center:** Would require the State Legislature to enact legislation relating to the development of the Fairview Developmental Center (Center) located in Costa Mesa, CA. Of note, the Governor's Fiscal Year 2019-2020 budget included funds to utilize the Center temporarily to provide housing and services for those experiencing a severe mental illness. Additionally, AB 1199, signed into law in 2019, allows a public hearing to determine the use of the Center. This bill is still early in the legislative process. The pending legislation to define use of the Center is unknown at this time.	**02/14/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2746 Petrie-Norris, Gabriel	**Accountability of State Funds Used for Homelessness:** Would require an agency that receives state funds for programs related to homelessness, including, but not limited to, the Whole-Person Care pilot program, California Work Opportunity and Responsibility to Kids (CalWORKs), or the Housing and Disability Income Advocacy Program, to submit a report regarding the use of state funds. The report would be sent to the state agency granting funds for these programs. Additionally, would require the report to the state agencies to be submitted within 90 days of receiving program funds, or by April 1, 2021, if the recipient already received program funds as of January 1, 2021.	**07/28/2020** Re-referred to Senate Committee on Human Services **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
AB 2848 Santiago	**Homelessness Reduction Plan:** Would require each city or county to develop a plan to reduce homelessness by no less than 10% each year through a state mandate. The plan would be effective no later than January 1, 2022 and would be under the direction of the state's Homeless Coordinating and Financing Council. Additionally, would authorize the Office of the Inspector General to be in compliance with the Homeless Reduction Plan.	**05/05/2020** Re-referred to Committee on Housing and Community Development **02/20/2020** Introduced	CalOptima: Watch
AB 3269 Chiu, Bloom, Bonta, Quirk-Silva, Santiago	**State and Local Homelessness Reduction Plan:** Would require the State Homeless Coordinating and Financing Council (coordinating council) to seek federal support from the Department of Housing and Urban Development (HUD), if available, to conduct a statewide needs and gaps analysis relating to homelessness. Would require the coordinating council to identify state programs that provide housing or services to individuals experiencing homelessness. With that information, would require the coordinating council to collaborate with HUD to create a financial model that will assess the costs of providing transitional support into permanent housing for those experiencing homelessness. Furthermore, this bill would require state and local agencies aim at reducing homelessness by 90% by December 31, 2028, based on the 2019 homeless point-in-time count. Would establish the Office of the Housing and Homelessness Inspector General to monitor the reduction plan and to bring action against a state and local agency that fails to adopt and implement a homelessness reduction plan within a reasonable time frame. Additionally, on or before January 1, 2022, each state and local agency shall develop an actionable plan to reduce homelessness and submit that plan to the Homeless Coordinating and Financing Council. This bill would also require HUD to set a benchmark goal for the reduction plan for each state and local agency to meet by January 1, 2028.	**07/02/2020** Referred to Senate Committee on Housing **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/21/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 3300 Bloom, Bonta, Gipson, Quirk-Silva, Santiago, Wicks	**California Access to Housing and Services Act:** Would authorize the Department of Finance to allocate no more than $2 billion General Fund to establish the California Access to Housing and Services Fund.	**08/04/2020** Hearing postponed by the committee **07/01/2020** Referred to Senate Committee on Housing **06/15/2020** Passed Assembly floor; Referred to Senate floor **02/21/2020** Introduced	CalOptima: Watch

MEDI-CAL MANAGED CARE PLANS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2625 Boerner Horvath	**Ground Emergency Medical Transportation (GEMT):** Would require managed care plans that offers coverage for GEMT services to include those services as in-network services.	**03/02/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
AB 2836 Chen	**Medi-Cal Emergency Medical Transportation Reimbursement Act:** Would impose a quality assurance fee (QAF) for each emergency medical transport provided by an emergency medical transport provider, beginning Fiscal Year 2021-2022. Would require the Department of Health Care Services to calculate the annual QAF to a specified program period at least 150 days before the start of the fiscal year. The bill would also redefine "emergency medical transport provider" to mean any provider of emergency medical transports, except during the entirety of any Medi-Cal managed care rating period.	**05/05/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
SB 936 Pan	**Medi-Cal Managed Care Plans Contract Procurement:** Would require the Department of Health Care Services Director to conduct a contract procurement at least once every five years with a contracted commercial Medi-Cal managed care plan providing care for Medi-Cal beneficiaries on a state-wide or limited geographic basis.	**02/20/2020** Referred to Committee on Health **02/06/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1938 Low, Eggman	**340B Discount Drug Purchasing Program:** Would define a "designated entity" eligible for the 340B discount drug purchasing program as a nonprofit organization, including any subsidiary of that organization, that individually or collectively meets specific requirements. This would require: ■ The designated entity to be a licensed managed care organization that has previously contracted with the department as a primary care case management organization; ■ The designated entity to be contracted with the federal Centers for Medicare and& Medicaid Services (CMS) to provide services in the Medicare Program as a Medicare special needs plan; and ■ The designated entity to be an existing participant of the 340B program. Additionally, would prohibit a designated entity from using any revenue from a contract with the Department of Health Care Services, a contract with CMS, and from the 340B program for specific activities, such as: ■ Funding litigation under the California Environmental Quality Act; or ■ Influencing or funding any ballot measure actions related to housing.	**05/19/2020** Passed Committee on Health; Referred to Committee on Appropriations **01/17/2020** Introduced	CalOptima: Watch
AB 2100 Wood	**Pharmacy Carve-Out Benefit:** Would require the Department of Health Care Services to establish the Independent Prescription Drug Medical Review System (IPDMRS) for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act, no sooner than January 1, 2021. Would require the IPDMRS to review disputed health care service of any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program that has been denied, modified, or delayed or to a finding that the service is not medically necessary. Additionally, would establish prior authorization requirements, such as a 24-hour response, a 72-hour supply during emergency situations, and a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list.	**08/01/2020** Passed Senate Committee on Health; Referred to Senate Committee on Appropriations **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/05/2020** Introduced	CalOptima: Watch
AB 2348 Wood	**Pharmacy Benefit Management (PBM):** Would require a PBM, who contracts with a health care service plan, beginning on October 1, 2021, to report to the Department of Managed Health Care the PBM's revenue, expenses, health care service plan contracts, the scope of services provided to that plan, and the number of enrollees the PBM serves. The PBM would also be required to submit a report on all covered prescription drugs, including generic, brand name, and specialty drugs dispenses at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use.	**05/05/2020** Referred to the Committee on Health **02/18/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 852 Pan	**California Affordable Drug Manufacturing Act of 2020:** Would establish the Office of Drug Contracting and Manufacturing (Office) to reduce the cost of prescription drugs. No later than January 1, 2022, would require the Office to contract or partner with no less than one drug company or generic drug manufacturer, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs.	**08/05/2020** Referred to Assembly Committee on Health **06/25/2020** Passed Senate floor; Referred to Assembly floor **05/13/2020** Passed Committee on Health **01/13/2020** Introduced	CalOptima: Watch CAHP: Support
SB 1084 Umberg	**Secure Dispensing of a Controlled Substance:** Would require a pharmacist who dispenses a controlled substance in a pill form to dispense the controlled substance in a lockable vial no sooner than June 30, 2021. Would require the manufacturer of the controlled substance to reimburse the pharmacy dispensing the medication the cost of using a lockable vial within 30 days of receiving a claim. Would also require the pharmacy to provide educational pamphlets to the patient regarding the use of a controlled substance.	**03/05/2020** Referred to Committees on Business, Professions and Economic Development; Judiciary **02/19/2020** Introduced	CalOptima: Watch

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2492 Choi	**Program of All-Inclusive Care for the Elderly (PACE) Enrollment:** Would require the Department of Health Care Services to establish a maximum number of eligible participants each PACE center can enroll.	**03/17/2020** Hearing postponed by Committee on Aging & Long-Term Care **03/12/2020** Referred to Committees on Health; Aging & Long-Term Care **02/19/2019** Introduced	CalOptima: Watch CalPACE: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2604 Carrillo	Pandemic and Health-Related Emergency Protocols for Health Facilities Act: During a health-related state of emergency or local emergency, would require a health facility to limit the possible introduction of a pathogen, infection, or illness that is related to a pandemic or emergency by: ■ Postponing non-emergency medical procedures or office visits; ■ Prohibiting or limiting visitors of patients to the health facility; ■ Ensuring all patients and staff are always wearing surgical masks or personal protective equipment; ■ Providing education and enforcing regarding hand hygiene and cough etiquette for patients and staff; ■ Regularly disinfecting the health facility at least three times per day; ■ Adding air cleaning equipment to ventilation systems; ■ Establishing contaminated, partially contaminated, and clean zones with buffers between each of the three zones; ■ Implementing outdoor triage stations; and ■ Considering all patients to have "suspected cases' of the pathogen, infection, or illness until ruled out or confirmed.	**05/07/2020** Re-referred to Committee on Labor and Employment **02/21/2020** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioners:** Would establish the Nurse Practitioner Advisory Committee to provide recommendations and advice to the Board of Registered Nursing. Would permit a nurse practitioner to practice without direct, ongoing supervision of a physician when practicing in an office managed by one or more physicians. Would also require the Board of Registered Nursing to define the minimum requirements for which a nurse practitioner may transition to practice without the direct, ongoing supervision of one or more physicians. If a nurse practitioner meets the minimum requirements, this bill would then authorize that nurse practitioner to perform specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances.	**07/23/2020** Re-referred to Senate Committee on Business, Professions and Economic Development **01/27/2020** Passed Assembly floor; Referred to Senate floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement**: Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**09/13/2019** Carry-over bill; Moved to inactive filed at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
AB 2871 Fong	**Drug Medi-Cal Reimbursement Rates:** Would require the Department of Health Care Services to establish reimbursement rates for services provided through the Drug Medi-Cal program to be equal to rates for similar services provided through the Medi-Cal Specialty Mental Health Services program.	**03/05/2020** Referred to Committee on Health **02/21/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support
AB 1676 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours. Would also require adequate staffing to ensure calls are answered within 60 seconds. Payment structure has yet to be defined.	**01/31/2020** Died in appropriations **05/16/2019** Committee on Appropriations; Held under submission **04/24/2019** Passed Committee on Health **02/22/2019** Introduced	CalOptima: Watch CAHP: Oppose
AB 2164 Rivas, Salas	**Expanding Access to Telehealth:** Would no longer require the first visit at a federally qualified health clinic to be an in-person visit by authorizing telehealth appointments that occur by synchronous real time or asynchronous store and forward. This would allow the new patient the option to utilize telehealth services and become an established patient as their first visit.	**08/01/2020** Passed Senate Committee on Health; Referred to Senate Committee on Appropriations **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/11/2020** Introduced	CalOptima: Watch LHPC: Support
AB 2360 Maienschein	**Mothers and Children Mental Health Support Act of 2020:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than July 1, 2021. Would permit telehealth services to be conducted by video or audio-only calls. Additionally, would require the telehealth consultation appointment to be completed by a mental health clinician with expertise in providing care for pregnant, postpartum, and pediatric patients. Would require access to a psychiatrist when deemed appropriate or requested by the treating provider.	**08/01/2020** Passed Senate Committee on Health; Referred to Senate Committee on Appropriations **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/19/2020** Introduced	CalOptima: Watch CAHP: Oppose LHPC: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 1278 Bradford	**Health Care Provider License for Telehealth:** Would require that accepted standards of practice applicable to a health care provider under the health care provider's license shall also apply to that health care provider while providing telehealth services.	**05/15/2020** Hearing canceled at the request of the author **03/05/2020** Referred to Committee on Business, Professions and Economic Development **02/21/2020** Introduced	CalOptima: Watch

TRAILER BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
Trailer Bill Medi-Cal Expansion	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals 65 years of age or older regardless of their immigration status. The Governor's Fiscal Year 2020-2021 proposed budget anticipates the expansion of full-scope Medi-Cal will cost $80.5 million ($62.4 million General Fund) in 2021 and $350 million ($320 million General Fund) each year after, including the cost of In-Home Supportive Services.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Drug Price Negotiations	**Med-Cal Drug Pricing Negotiations:** Would authorize the Department of Health Care Services negotiate "best prices" with drug manufacturers, both within and outside of the United States, and to establish and administer a drug rebate program in order to collect rebate payments from drug manufacturers for drugs furnished to California residents who are ineligible for full-scope Medi-Cal. Would authorize a Medi-Cal beneficiary to receive more than six medications without prior approvals. Additionally, this Trailer Bill would modify the current co-pay amount for a drug prescription refill.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Medication-Assisted Treatment	**Medication-Assisted Treatment (MAT):** Would expand narcotic treatment program services to include MAT under Drug Medi-Cal.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Managed Care Savings and Efficiencies	**Managed Care Savings and Efficiencies:** In alignment with the 2020-2021 State Budget May Revise, would reduce Medi-Cal capitation rate increments by up to 1.5 percent for capitation rates associated with the July 1, 2019 through December 31, 2020 rate period. Additionally, the Department of Health Care Services (DHCS) would be able to apply these reduced capitation rates for rating periods starting on or after January 1, 2021 and to account for the impacts of the COVD-19 public health emergency. To ensure capitation rates are actuarily sound, DHCS would be required to evaluate the impact of the changes in the level of health care funding for health care services on capitation rates it develops and pays under any applicable managed care health plan contract with a Medi-Cal managed care plan.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
Trailer Bill Federally Qualified Health Center and Rural Health Clinic Prospective Payment System Carve-Outs	**Elimination of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Prospective Payment System (PPS) Carve-Outs for Pharmacy and Dental Services:** Would require all Medi-Cal covered services provided by an FQHC or RHC, including but not limited to pharmacy and dental services, to be reimbursed only through the clinic's PPS rate, effective January 1, 2021. If an FQHC or RHC is unable to revert to its prior base PPS rate, it would be required to adjust the FQHC or RHC PPS base rate through scope-of-service adjustments. Of note, this Trailer Bill language would exclude any payment changes for services related to specialty mental health and Drug Medi-Cal.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Proposition 56 Payments	**Sunset of Proposition 56 Value-Based Payments:** In alignment with the 2020-2021 State Budget May Revise, would eliminate the Proposition 56 Value-Based Payment Program for provider incentive payments, effective July 1, 2020.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill COVID-19 Medi-Cal Response	**COVID-19 Medi-Cal Response:** Would require the Department of Health Care Services to implement any federal Medicaid program waivers or flexibilities approved by the Centers for Medicare & Medicaid Services related to the COVID-19 pandemic, pending approval from the State Department of Finance. Additionally, would require DHCS to continue providing COVID-19 related testing and treatment for individuals currently uninsured, regardless of immigration status, through Medi-Cal fee-for-service. This would be in effect for the duration of the State of Emergency.	**05/22/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Nursing Facility Financing Reform	**Nursing Facility Financing Reform:** Would make modifications to the skilled nursing facility (SNF) Quality Assurance Fees (QAFs): ■ Would exempt a unit that provides freestanding pediatric subacute care services in a SNF from the QAF for the rate period of August 1, 20202 through December 31, 2020, and every subsequent calendar year after; ■ Would allow the Department of Health Care Services (DHCS) to enforce new mechanisms for the collection of delinquent QAFs; and ■ Expand the use of the SNF Quality and Accountability Special Fund to December 31, 2021. Additionally, would adjust the Medi-Cal reimbursement rate methodology for the rate period of August 1, 2020 to December 31, 2020 to be no less than the rates established for 2019-2020 and no more than the applicable federal upper payment limit.	**05/26/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Long-Term Care at Home	**Long-Term Care at Home:** Would include long-term care services at home as a Medi-Cal covered benefit for beneficiaries enrolled in managed care and fee-for-service. Would require the entity providing long-term care at home benefits to be licensed and certified by the California Department of Public Health. Additionally, would require the benefit to include services such as, health assessments, transitional care services, care coordination, and home- and community-based services.	**06/12/2020** Published on the Department of Finance website	CalOptima: Watch

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

2020 Federal Legislative Dates

April 4–19	Spring recess
August 10–September 7	Summer recess
October 12–November 6	Fall recess

2020 State Legislative Dates*

**Due to COVID-19, 2020 State Legislative dates have been modified*

January 6	Legislature reconvenes
January 31	Last day for bills introduced in 2019 to pass their house of origin
February 21	Last day for legislation to be introduced
April 2–12	Spring recess
May 22	Last day for policy committees to hear and report bills to fiscal committees introduced in the Assembly
May 29	Last day for policy committees to hear and report bills to fiscal committees introduced in the Senate
May 29	Last day for policy committees to hear and report to the floor non-fiscal bills introduced in the Assembly
June 5	Last day for fiscal committees hear and report to the floor bills introduced in the Assembly
June 15	Budget bill must be passed by midnight
June 15–19	Assembly floor session only
June 19	Last day for the Assembly to pass bills in their house of origin
June 19	Last day for fiscal committees to hear and report to the floor bills introduced in the Senate
June 22–26	Senate floor session only
June 26	Last day for the Senate to pass bills in their house of origin
July 2–July 27one	Summer recess
July 31	Last day for policy committees to hear and report fiscal bills to fiscal committees
August 7	Last day for policy committees to meet and report bills to the floor
August 14	Last day for fiscal committees to report bills to the floor
August 17–31	Floor session only
August 21	Last day to amend bills on the floor
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 3	General Election
December 7	Convening of the 2021–22 session

Sources: 2020 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
September 3, 2020

CalOptima Community Outreach Summary — August 2020

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events and public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima's staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Event Update

The Community Relations department strives to strengthen partnerships by enhancing communications, understanding and mutual support between CalOptima and community organizations to serve our members' health care needs. Given **46**% of CalOptima's membership identify as Latino and **25**% identify Spanish as their primary language, CalOptima recognizes the importance of developing strong relationships with organizations that work closely with the Latino community. Since July 2016, the Community Relations department has been hosting Cafecito as a way for key stakeholders to increase their knowledge and understanding of CalOptima, Medi-Cal's programs and services and various programs and services, while developing partnerships with community-based organizations serving the Latino community.

On Wednesday, June 24th Community Relations partnered with Orange County Social Services Agency (SSA) and 211 Orange County to host our 2nd virtual Cafecito meeting. There were 46 stakeholders in attendance to learn about community resources available during the COVID-19 pandemic. SSA shared how Medi-Cal enrollment services have pivoted in response to COVID 19, eligibility guidelines and information about the General Relief and Pandemic Electronic Benefit Transfer programs. 211 Orange County shared information on community resources and demonstrated how to navigate their services via telephone, text and on-line search tools. Hope Builders, Regional Center of Orange County, Family Caregiver Resource Center and the LGBT Center OC, as well as representatives from the Santa Ana Unified and Anaheim Elementary School Districts were some of the organizations in attendance.

Back to Agenda

Prior to COVID-19, Cafecito meetings were held in-person, however transitioning meetings to an on-line platform has provided opportunities for increased attendance. Meeting attendance at both the April and June Cafecito meetings was double the pre-COVID in person meetings, which reinforces the importance of sharing resources and remaining connected during these challenging times.

For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities
CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

As of July 31, 2020, **through virtual meetings and teleconferences** CalOptima expects to participate in 18 community events, coalition and committee meetings during August.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
8/04/2020	• Collaborative to Assist Motel Families Meeting (Virtual Meeting)
8/05/2020	• Orange County Aging Services Collaborative Meeting (Virtual Meeting) • Orange County Aging Services Collaborative Healthcare Committee Meeting (Virtual Meeting) • Anaheim Human Service Providers Network Meeting (Virtual Meeting)
8/10/2020	• Orange County Veteran's and Military Families Collaborative Meeting (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting)
8/11/2020	• Orange County Cancer Coalition Meeting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
8/13/2020	• Kid Healthy Community Advisory Council (Virtual Meeting) • Buena Park Collaborative Meeting (Virtual Meeting)
8/17/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee (Virtual format)
8/19/2020	• Orange County Communications Workgroup Meeting (Teleconference) • Covered Orange County Steering Committee Meeting (Teleconference)
8/20/2020	• Orange County Children's Partnership Committee Meeting (Virtual Meeting) • Orange County Strategic Plan for Aging Data Task Force Meeting (Virtual Meeting)

Back to Agenda

8/24/2020	• Stanton Collaborative Meeting (Virtual Meeting) • Community Health Research and Exchange (Virtual Meeting)
8/27/2020	• Orange County Care Coordination for Kids (Virtual Meeting)

As of July 31, 2020, CalOptima expects to organize or convene 4 community stakeholder events, meetings or presentations through virtual meetings or teleconferences during August.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
8/13/2020	• 2020 Great American Smoke Out Planning Meeting (Virtual Meeting)
8/20/2020	• Health Network Forum (Virtual Meeting)
8/26/2020	• CalOptima Cafecito Meeting (Virtual Meeting)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
8/19/2020	• Community-Based Organization Presentation to Padres Mentores — Topic: Medi-Cal in Orange County (Spanish Virtual Presentation)

CalOptima provided zero endorsements consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

Back to Agenda

CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima is transitioning how we engage with our community partners and will not be attending in-person Community Collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima has updated our participation in Community Collaborative meetings and community events. With respect to events that have been cancelled or postponed due to COVID-19 in which sponsorship or fees have already been paid, event organizers will be provided the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events, provided the future event(s) meet the criteria set forth in Policy AA.1123 and meets eligibility requirements indicated by Board of Directors.

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.

September

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Tuesday, 9/1 9:30–11 a.m. (Virtual format)	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Thursday, 9/3 9–11 a.m. (Virtual format)	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 9/3 11 a.m.–1 p.m. (Virtual format)	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Courtyard Center 12732 Main St. Garden Grove
Tuesday, 9/8 10–11:30 a.m. (Virtual format)	++ Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 9/8 3:30–5:30 p.m. (Virtual format)	++ San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Wednesday, 9/9 3:30–4:30 p.m. (Conference call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 9/10 8 a.m.–12 p.m. (Virtual format)	+ UCI MIND and Alzheimer's Orange County's Annual SoCal Alzheimer's Disease Research Conference	Conference Open to the Public Registration recommended	Sponsorship $250 1 Staff	Virtual Platform
Thursday, 9/10 10–11:30 a.m. (Virtual format)	++Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Community Center 6640 Beach Blvd. Buena Park

Thursday, 9/10 11 a.m.–12:30 p.m. (Virtual format)	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 9/10 12:30–1:30 p.m. (Conference call)	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Hive 1725 S. Douglas Rd. Anaheim
Thursday, 9/10 3:30–5:30 p.m. (Virtual format)	++ State Council on Developmental Disabilities Regional Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana
Friday, 9/11 9–11 a.m. (Virtual format)	++ Orange County Diabetes Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Health Care Agency 1725 W. 17th St, Santa Ana
Monday, 9/14 1–2:30 p.m. (Virtual format)	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 9/14 2:30–3:30 p.m. (Virtual format)	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 9/15 8:30–10 a.m. (Virtual format)	++North Orange County Senior Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 9/15 11 a.m.–12 p.m. (Conference call)	++Placentia Community Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Placentia Library 411 Chapman Ave. Placentia
Wednesday, 9/16 9–10:30 a.m. (Conference call)	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Thursday, 9/17 8:30–10 a.m. (Virtual format)	++ Orange County Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall Administration 10 Civic Center Plaza Santa Ana

Thursday, 9/17 2:30–4:30 p.m. (Virtual format)	++Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Monday, 9/21 1–4 p.m. (Virtual format)	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Community Center 505 E. Central Ave. Santa Ana
Wednesday, 9/23 11:30 a.m.–12:30 p.m. (Virtual format)	+UCI Health's Vendor Fair	Health/Resource Fair Open to the Public	1 Staff	Virtual Platform
Thursday, 9/24 1:30–3:30 p.m. (Virtual format)	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	CHOC Centrum Building 1120 W. La Veta Orange
Monday, 9/28 12:30–1:30 p.m. (Virtual format)	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton